State of Maryland / Department of Health and Mental Hygiene

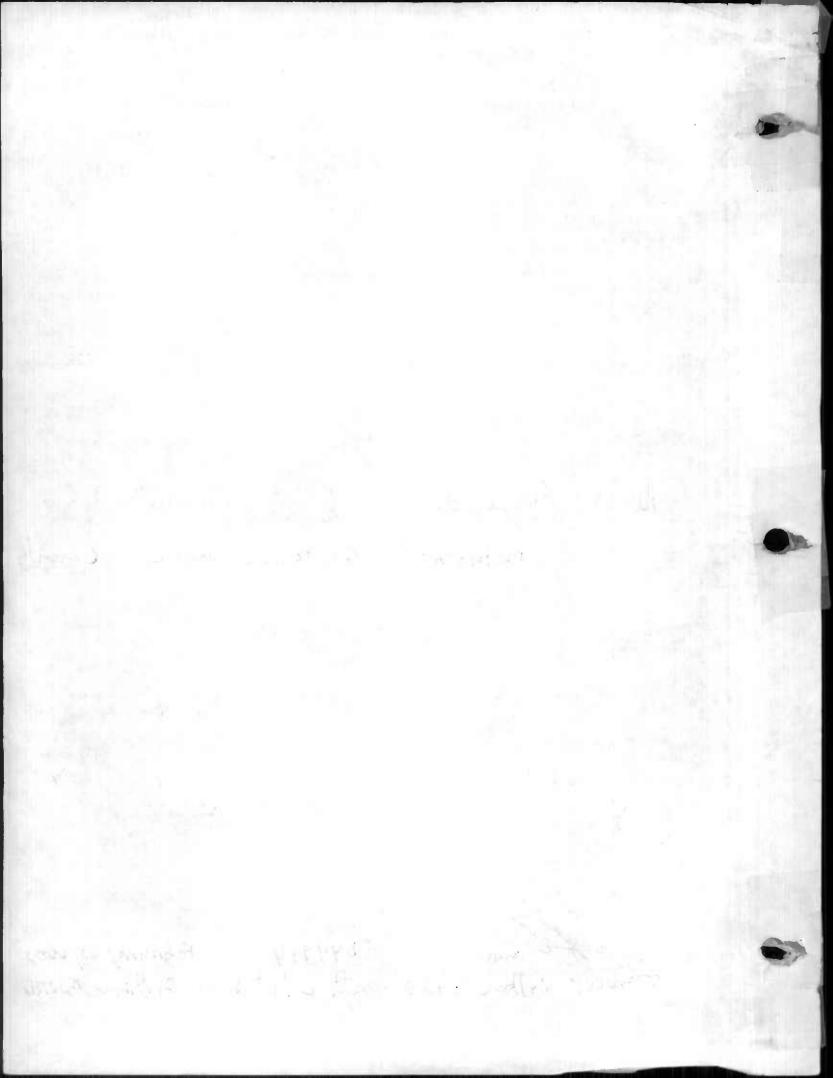
hysician							/	1	Reg. No.			_
/Medical	1. Decedent's Name (First, Middle, Bertha Fren	ch Mathi	eson						24, Day 20	O Qer	3. Time of Deat 2:37A.	h
miner	4a Facility Name (# not institution, 4107 Ravenhur					4b. City, To	111	ocation of Deat		y of Death imore		
	5. Social Security Number 579–10–0786	6. Sex 7. Age 1 M 2 X F	e (In yrs. la:	St birthdey)	If Under 1 Yes Months Day		r 24 Hrs. Min.	8. Date of Bi	nth ay 1'91'8	9. Birthp Virg.	lece (State or Fore	Bigi
	Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Loc	ation					1	0d. Inside City Lim	nits
Director	Maryland Baltin	nore		n Arm					1 ☐ Yes 2 🛣			
	10e. Street and Number 4107 Ravenhurs	t Circle			10f. Zip Code 21057					10g. Citizen of What Country? United States		
by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🏋 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? od 1 Yes 2 N If Yes, Give Year or Dates:		I,S. 13. Was Decedent of Hispanic Origin It Yes, specify Cuban, Mexican, Po				ecify Yes or No Rican, etc.)		14. Rece - American Indian, Black, White, etc. Specify: White		
eted	15. Decedent's (Specify only highest			16a. Decede	ent's Usual Occ kind of work don O NOT use reti	supation ne during mo	st of work	ing	16b. Kind of I			
Completed	Elementary/Secondary (0-12)	College (1-4or 5	3)	_	o NOT use reti stered N				Washin			
To Be Co	17. Fether's Name (First, Middle, L. John	ast)	1	Conas		18. Moth	ner's Nem a rl	e (First, Middle	, Maiden Sume	me)	Meador	
	19a. Informant's Name/Relationshi Robert D. Mathie				as #10	et and Numi	ber or Rur	al Route Numb	per, City or Town	n, State, Zip	Code)	
Department of Health and Mer Important: if tem 27 is marke any injury or other traumatic pace. To	20a. Method of Disposition 1 Burial 2 X Cremetion 3 4 Donation 5 Other (Spe		cer	netery, crem	ition (Name of atory or other p		y 2/2	Date 27/2000	20c. Location		wn, State Virginia	a
	21. Signature of Funeral Service Li	Brown	dd	Do		Borg	wardt		al Home		land 207	05
edicai Examiner	Immediate Cause (Finat disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (or a	as a consequence as a c	uence ot):	ote,	TC.	C 19	ven		6 mon.][
n/Med	resulting in death) cast											
3	Section Administration	d									4-14	
/sician	Part II. Other significant condition	d	ut not result	ing in the un		given in Part	1.	23b. Dtd	tobacco use c	ontribute to	o the cause of dea	uth 1
Physicia	Part tt. Other significant condition	de contributing to death bu	ut not result	ing in the un		given in Part	(L		Yes 2 No			
by Physicia	Part tt. Other significant condition	d	ut not result	ing in the un		given in Part	(I.	1 🗆		3 Prof		now gs
by Physicia	Part It. Other significant condition	d	ut not result	ing in the un		given in Part	1.	1 24e. Was	Yea 2 No	3 Prof	bably 4 Unkr	now gs
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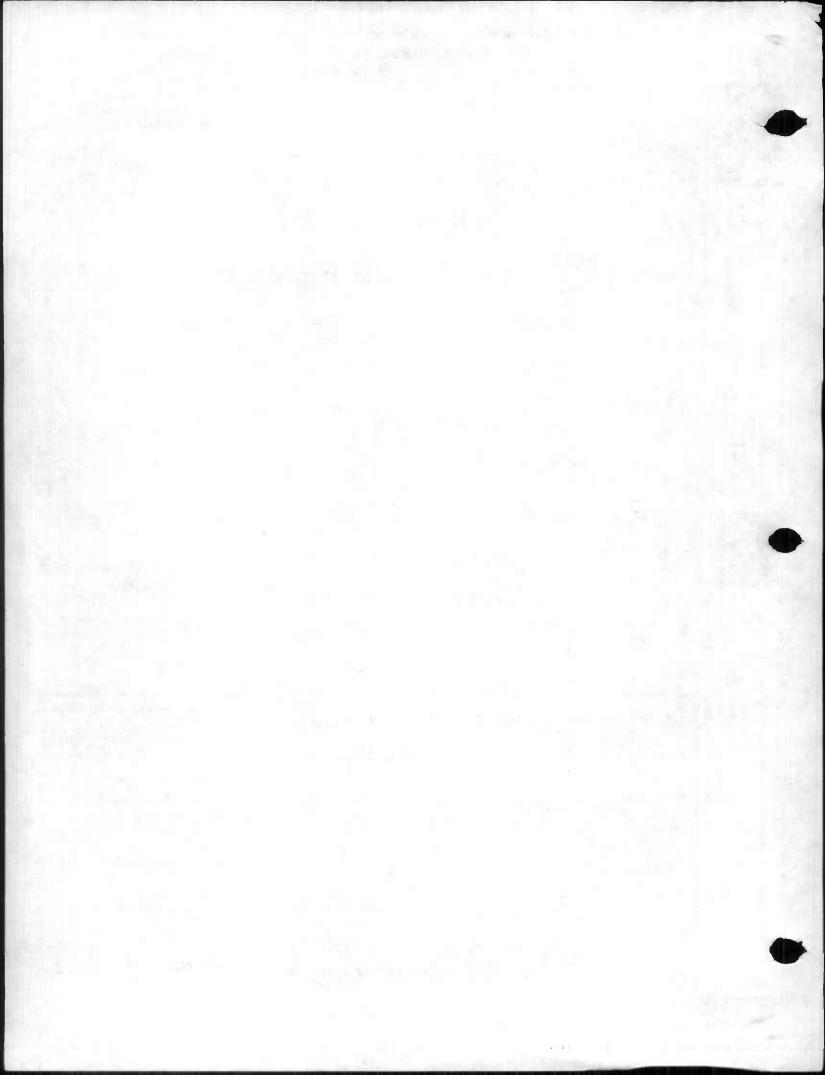
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State of Maryland / Department of Health and Mental Hygiene

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Funeral Director	10e. Street	and Number					10f. Zip	Code		7		10g. Citiz	en of What	t Country	?
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	19e. Inform	ant's Name/Relation								-	I Route Numi	ber, City or	Town, Sta	ite, Zip C	ode)
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State of Maryland / Department of Health and Mental Hygiene

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Birthplaca (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

Maryland

10g. Citizen of What Country?

	Physician
	/Medical
7	Examiner

DAVIAMENDRANO. #23 PART I, 27, 28A-F PER MEO Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death 28, 2000 0852 AM David Sergio FEB. Medrano 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE ADVENTIST HOSPITAL GAITHERSBURG MONTGOMERY

10f. Zio Code

Months

7. Age (In yrs. last birthday)

Yrs.

10c. City. Town or Location

If Under 1 Year | If Under 24 Hrs.

Gaithersburg

Hours

Davs

8. Dete of Birth (Month, Day, Year)

Feb. 23, 2000

Funeral

5. Social Security Number

Usual Residence of Decedent

10b. County

n/a

Maryland

10e. Street and Number

10a. State

6. Sex

Montgomery

1♥M 2□ F

Director - how

the Meryland Directo

permit. Pages 1 end 2 should be filed within 72 hours efter deeth with the Meryla Department of Haelth and Mental Hygiena. Importants if item 27 is marked other than "natural", or items 23s or 28s-f show any liqury or other treumstic avent, the Medical Exprise must be notified a sonia.

altimore, Maryland 21215-0020

Box 68760

P.O.

Records,

Division of Vital

Physician /Medical Examiner

physician and the buriel-transit that the death cartificate for use as signed by the lew requires should I 986 paga 2 or Attending Physician: the state of funeral After To the Hospital or Attandin within 24 hours effer dash.
To the Funeral Director: Af completely filled in by the fu deeth.

1140 West Side Dr. 20878 United States Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give XIX Never Married 2 Merried 1 N Yes 2 No Specify: Salvadorian Specify: White p 3 Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a n/a 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jorge Medrano Theresa Vascones 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jorge Medrano / Father 1140 West Side Dr., Gaithersburg, MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) March 2 Chesapeake Crematory Inc 2000 Beltsville, MD Rappe Platers Fed d Cremation Services Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, MD 2 Dolleman 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death SUDDEN UNEXPLAINED INFANT DEATH Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Unknown p 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 12 Yes 2 □ No 1 Yes 2 No 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient XX ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XXes 2□ No Medical Certification: To 27, Manner of Death 28a. Dete of Injury (Month, Day Year) FOUND: 2 = 28 = 00 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending investigation 1 Natural UNKNOWN M 1 Yes 2 No 2 Accident HNKNOWN 6X Could not be 3 Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28t. Location (Street and Number or Rucal Route Number, City or Town, State) 1140 WEST SIDE DR 4 Homicide HOME COUNTY, MARYLAND 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner es stated.

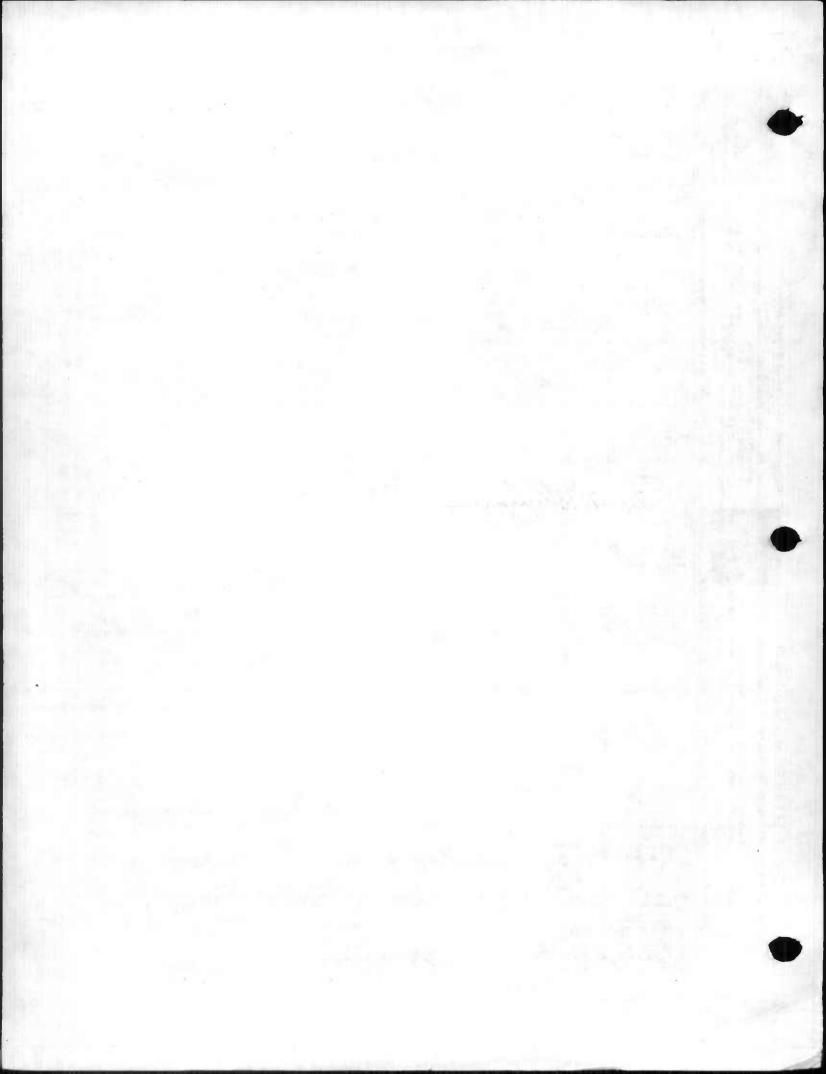
2 Aldedical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) O.C.M.E FEB. 29, 2000 30. Name and address of person who completed cause of death (Item/23a) (Type, Print) 111 Penn Street, 21201, BALTIMORE.MARYLAND Radentz Strphen S, 31. Date filed (Month, Day, Year) 5,

State Registrar

MAR 03

2000

32. Figureture Signeture



State of Maryland / Department of Health and Mental Hygiene 08504 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Date of Death Month Day 74, 2000 **Physician** William. A. Moulden 2:00 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 24, 1924 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** DEM 20 F 218-16-0406 76 Yes Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 ☐ No Director Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code United States of America 9929 Capitol View Avenue 20910 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedenf Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1XIVes 2 No If Yes, Give 1 Year or Dates: 1 Never Married 20 Married 1 Yes 210No Specify: 1945-46 Specify: à 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Supervisor Manufacturing 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 2 Charles Howard Moulden Mary Catherine Hale 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heelth at Important: If Item 27 is any injury or other trau 2008. Martha J. Moulden/wife 9929 Capitol View Avenue Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State t⊠Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Church Cem. 2/28/00 Winchester, Virginia 4 Donation 5 Other (Spec 21. Signature of Feheral Service Uce 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. has 11800 New Hampshire Ave. Silver Spring, MD 20904 234. Part1. Enter the diseas shock, or heert feilure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onsef and Death Physician Immedia disease or condition resulting in death) /Medical CLOSTRIDIUM DIFFICILE ENTEROCOLITIS Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ARTERIOSCLEROTIC CORONARY VASCULAR DISEASE þ 24b. Were eutopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yas 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1XXnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending 1 Netural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Medical 29e. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D340342 February 24,2000 and cause of death (fem 23a) (Type, Print) 30. Name and address of person who comple 3720 Farragut Avenue Kensington, MD Jeane P. Asher, M.D. 31. Date filed (Month, Day, Year) FEB 2 8

State Registrar

DHMH 16 Rev 6/95

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Pages 1 and 2 should be nent of Health and Mental

The law requires that the death certificate be executed

P.O. Box 68760.

Records.

Division of Vital or Attending Physician: the burial-tran

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page 2 should

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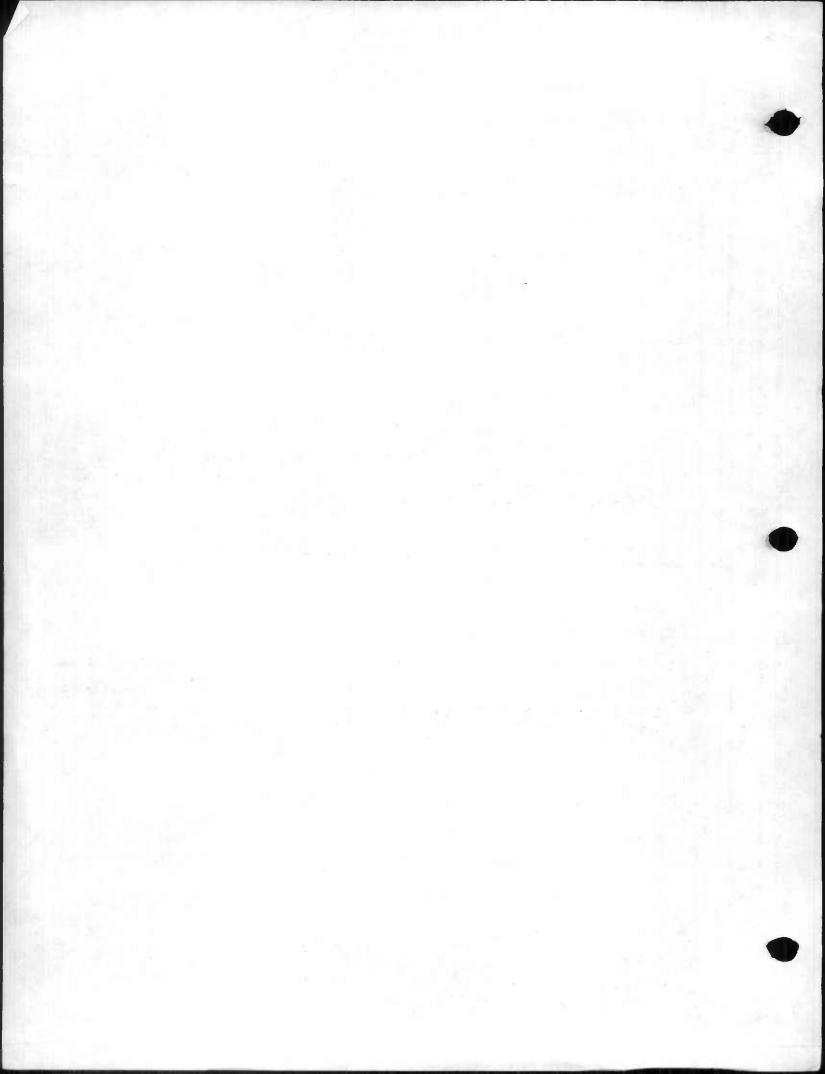
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Maryland 21215-0020

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32. Begistrar's Signatu

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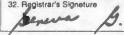


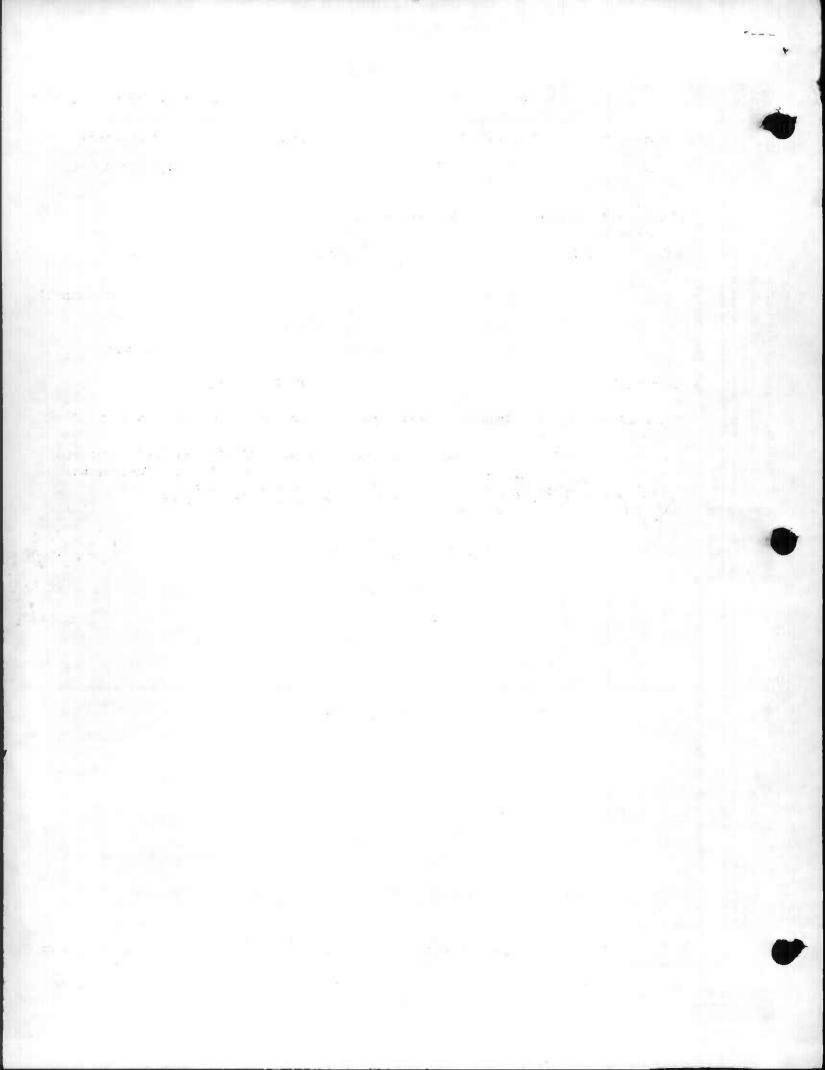
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edical niner	4a Facility Name (If not Insti	tution, give	street end nur	nber)			4b. City, Town, o	Location of Death	4c. County	of Death	
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al or	5. Social Security Number N/A		×]M 2∏F	7. Age (In yrs.	lest birthday) Yrs.	If Undar 1 Yaar Months Days	If Under 24 Hr Hours Mir		Year) n) 1943		ace (Stete or Foreign y) .stan
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rec	10e. Street and Number	Gomer	,	01.	IVCI OP	10f. Zip Coda		1	Og. Citizen of V	Vhat Count	ry?
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0	19a. Informant's Name/Rela	tionship /Tv	rpe. Print)		19b. Maiiir	ng Address (Street		Rural Route Number	r. City or Town.	Stete. Zip (Code)
	Dr. Ghulam Da			hew	433 B	onifant	Road, Si	lver Spr	ing, Ma	rylan	1 20905
	20a. Method of Disposition	Λ		20b.	Place of Dispo	sition (Neme of netory or other ple			20c. Location -		
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	21. Signature of Funaral Se	1	00 4	-,	-			lines-Rin			
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-	23a Wartt, Engler the diseas	e, or compli	ications that c	eused the dea		.1ver Spr		cyland 20 ac or respiratory err	0904		Approximate
H	heart failure.	List only or	ne ceuse on e	ach line.							Interval Between Onset and Death
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i	that initiated events resulting in death) Last			Due to (or as a conseq	uence of):					
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ay inystoleting											
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	exeminer?	-	lospital:	npatient 2	ER/Outpatien	t 3D DOA Ot	hoe	Homa 5 ☐ Resid		er (Snecity)
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	1 Neturel 5 Pr	ending vastigation	(Mont	h, Dey Year)	Injury		Yes 2 □ No				
	3 ☐ Suicide 6 ☐ C	ould not be etermined	28e. Place	of Injury - At h	nome, farm, str	eet, factory, office		28f. Location (S City or Tow	treet end Numb	per or Rural	Route Number,
	4 D Fromido		Dundii	ig, etc. (Speci	ny)			City of Tow	71, 31010)		
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-	one)			er stated.	ation and/or in						
	29b. Signature and title of ce	rtifier	11	0	7 IA	29c. Licen	sa number	4	29d. Date signe	d (Month, E	Day, Year)
	Ane	M	lle	rel	le ru	1)3	826	2 1	ebrua	ma.	2000
	30. Name and address of pe	rson who co	•					2 1 340 Roc	104	MO	
	Dr Mendhi	ratta			earch	BLVD	Sule	340 KBC	Fulle	2	0350
	31. Data filed (Month, Day, 1	. 0.11.		egistrar's Sign		.5000	Jang	710		~	0030

State Registrar

FEB 2 8 2000





AMENDED LINE #1 HCHD 2-25-00 CAJ
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Amend item#8 3/01/00 HCHD BRH Certificate of Death CA.T Res No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death EDITH ELIZABETH MERRIKEN Month **Physician** ELIZABETH MERRIKE FEB 140-HA ,2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FALLSTON GENERAL HOSPITAL HALFORI FALLSTON 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (Stete or Foreign Country) **Funeral** Months Deys 10 M 2 F Director Nov. 24, 1914 212-01-2647 Maryland Usual Residence of Deceden NOV. 25, 1914 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits show. 1 Yes 2 No 288-1 Directo Maryland Harford Abinadon 10e, Street and Number 10f. Zio Code 10g. Citizen of What Country? "natural", or herns 23s or 20 Box Hill South Parkway Apt. 321 21009 USA 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 D No
If Yes, Give
Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after 1 Never Merried 2 Merried altimore, Maryland 21215-0020 Specify: White 1 Yes 2 No Specify: ğ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 ahould be flied w Department of Health and Mental Hygien Important; if Nen 27 is married other tha any injury or other traumatic. Petroleum Manfacturer Clerk 12 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middle, Last) 8 John u/k Lessner Bertha Elizabeth Smallwood 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 298 Canterbury Road, Bel Air, Maryland 21014 Audrey O. Miller-sister 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State
4 Donation 5 Other (Specify) Hilltop Services Corp. 2-25-00 Towson, Maryland 22. Name end Address of Fecility
McComas Funeral Home, P.A. th Funeral Service Licenses 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part I. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete intervel Between Onset end Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical ASCVD Examiner Due to (or as a consequence of): Examine physicien and s the burlei-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, edical Due to (or es e consequence of): Physician/M 080 Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation Attending deeth. To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier Medical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and manner as steted. (Check only 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner steted. 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Dev. Year) OCME FEB 22. 2000 DME 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) S.PRABHU MD 21014 MD 728 BELMIL NO 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State FED 2 4 2000 Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Deeth **Physician** JANE FAUCETT MUDD 2000 11:55PM March /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Charles County Nursing Rehab Center La Plata Charles 7. Aga (In yrs. last birthday) | If Undar 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) Birthplece (State or Foreign
Country) **Funeral** 10 M 2XX Months Deys 578-05-1402 85 Yrs. APRIL 11,1914 Director INDIANA Usuel Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director MARYLAND CHARLES LA PLATA 10e. Street end Number 10f. Zip Coda 10g. Citizen of Whet Country? 10200 LA PLATA ROAD 20646 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yas, spacify Cuben, Mexicen, Puarto Rican, etc.) 14. Race - Amarican Indien, Bieck, White, etc. 1 Yes 2 No tf Yes, Give Yaar or Dates: 1 Navar Marriad 2 Married 1 Yes 2 No Specify: þ 3 Nidowed 4 Divorced WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fathar's Neme (First, Middla, Last) Be GEORGE McCLENNAN FAUCETT EDITH DAVISON 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL T. MUDD - SON 12850 EDELEN ROAD BRYANTOWN, MD. 20617 20e. Method of Disposition 20b. Ptece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata Dete 1 Buriel 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify) METROPOLITAN CREMATORY 3-2-00 ALEXANDRIA, VA. 2. Name and Addrass of Facility 21. Signeture of Fugural Sa M00479 RAYMOND FUNERAL SERVICE, P.A. rel LA PLATA, MARYLAND 20646 is the caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, and on each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one cause Approximata intervel Between Onset end Deeth **Physician** /Medical immediate Cause (Final Dementia disease or condition resulting in deeth) **Examiner** Due to (or as a consequence of): Examiner Cerebralvasular Thrombosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequence of): and burial-tran physician certificate be Physician/Medical the Due to (or es e consequence of): 80 ettending nse 0 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Hypertension signed l λq 24b. Were eutopsy findings available prior to Completed 24a. Wes en eutopsy peen completion of ceuse of deeth? page 2 certificate 1 Yes 3/3/NX 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medical examiner? Physician: Be 26. Place of Deeth (Check only one) Other: Whursing Homa 5 Rasidence 6 Othar (Specify) Hospitel: 1 ☐ Inpatiant 2 ☐ ER/Outpetient 3 ☐ DOA P 1 ☐ Yes XIX No this funerai 27. Manner of Deeth 28a. Dete of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. injury et Work? After Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify) in by 4 ☐ Homicide

Records. Division of Vital i or Attending effer deeth. Hospital 624 hours e Funeral D To the To the To the

Box 68760

29b. Signatura and title of certifier 7 & Bule M

ACCertifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29c. Licansa number

29d. Data signed (Month, Dey, Year)

D0001009

March 2, 2000

30. Nema and address of person who completed ceuse of deeth (Item 23e) (Type, Print)

Henry L. Burke, MD., 115A La Grange Avenue, MD 20646

State Registrar

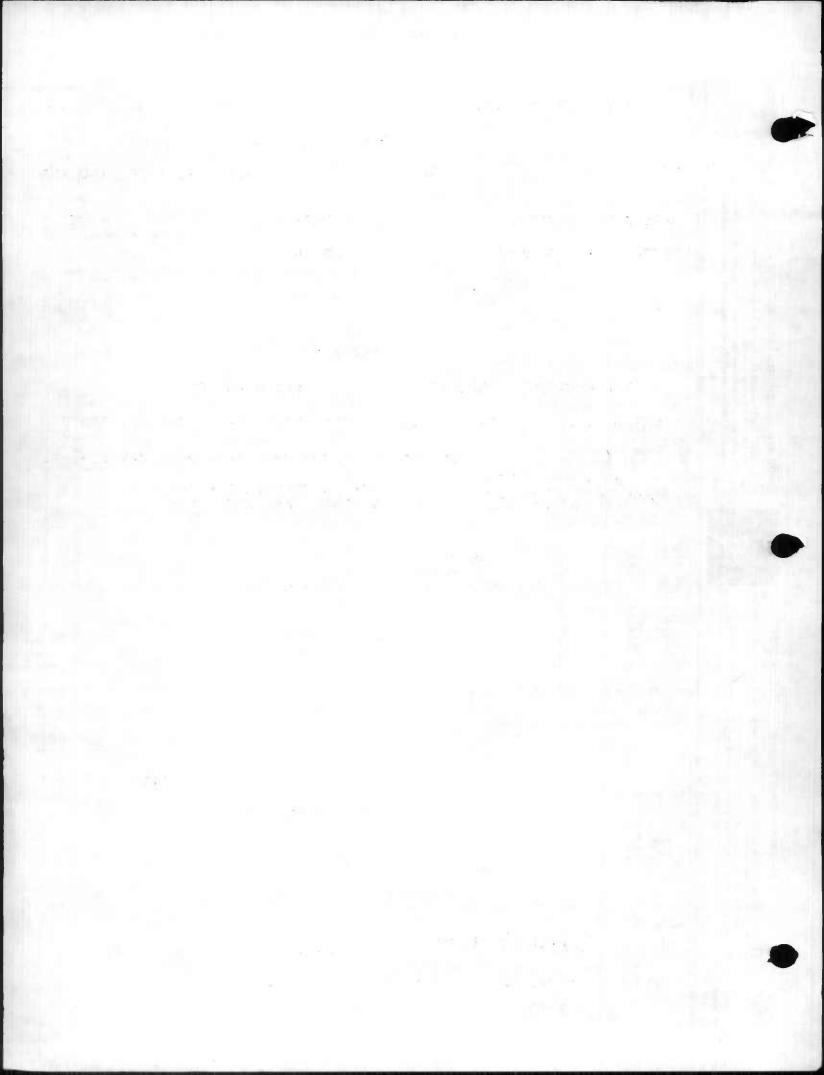
edical

29a. Certifier (Check only one)

31. Date filed (Month, Day, Year) MAR 03 2000

32. Registrer's Signature

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State of Maryland / Department of Health and Mental Hygiene

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aoral	5. Social Security		Sex		yrs. lest birtho		ndar 1 Yaar	If Under	24 Hrs.	8. Date of B			place (Steta or Fore
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ToB		AR	CHIBALD	DIXO	V					MARC	GARET KO	ONTZ	
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any injury or other tri	4 Donation	n 5 ☐ Other (Speci	ify)		SUNSE	Г МЕМ	ORIAL	PARK		2000	CUM	BERLA	AND, MD
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State of Maryland / Department of Health and Mental Hygiene

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	sician	MARY ANN MA	AGELITZ					F	Month ebruar	Day 19,	2000	1920
•	edical	4a Facility Name (If not Institution, gi					4b. City, Tox		ion of Death	4c. County		1920
EXa	miner											
		Memorial Hospita 5. Social Security Number 6.		(In yrs. last bir	thefaul If Line	fer 1 Year	Cumb	perlan	Date of Birth	A11	egany	
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Direct	tor	211-12-2407	Λ (84				AC	G. 1,1	915	NEW	JERSEY
2 8		Usual Residence of Decedent 10e. State 10b. County		10c. City, Tow	n or Location			_			1	0d. Inside City Lim
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Maryjand 21215-0020 td 2 should be fined within 72 hours at th and Marital Faglene. The and Marital Faglene. The survived other than "natural", or traumatic event, the Medical Exam.		19e. Informant's Name/Relationship			. Mailing Addre							Code)
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ON.		23a. Part1. Enter the disease, or con shock, or heart failure. List only	one cause on each line	ne death. Doi).	tot enter the m	oae or ayı	ng, such es	cardiac or re	spiratory arre	est,	1	Approximate Interval Between
Physicia												Onset and Death
/ /Medic Examin		Immediate Cause (Final disease or condition	ASPIRA	TION P	NEIMONT	Λ.						3 WEEKS
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	Ü	25. Was case referred to medical					44.00			-	1	Yes 2 No
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Affer funer	ou	1 Matural 5 ☐ Panding	28e. Date of Injury (Month, Day)		ima of njury	28c. Injui Wo			. Describe ho	w injury occur	red	
or Attending after death. Director: After din by the fune	Cat	2 Accident investigation			М	10	Yes 2 1	No				
or Attendate deat Director:	=	3 Suicide 6 Could not to determined	28e. Place of Injury building, etc.		rm, street, fact	ory, office		28f	Location (St. City or Town		ber or Rura	I Route Number,
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hour hour y		29a. Certifier Certifying Pt	hysician: To the best of	my knowledge	death occurre	d at the tir	ne, date and	d place, end	due to the ca	use(s) and m	enner as st	lated.
To the Hospital or Attent within 24 hours after deal To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Example)	miner: On the basis of e and menner stete	xamination and	Vor investigation	on, in my o	pinion, deet	th occurred	at tha time, de	ate and place,	end due to	the cause(s)
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14		30. Name and address of person who	completed cause of dea	th (Item 23a) (Type, Print)						,	
1	LKS	Dr. Boyd Sprenkl	e, Memorial	Hospi	tal. 60	0 Men	norial	Ave.	Cumb	erland.	MD	21502
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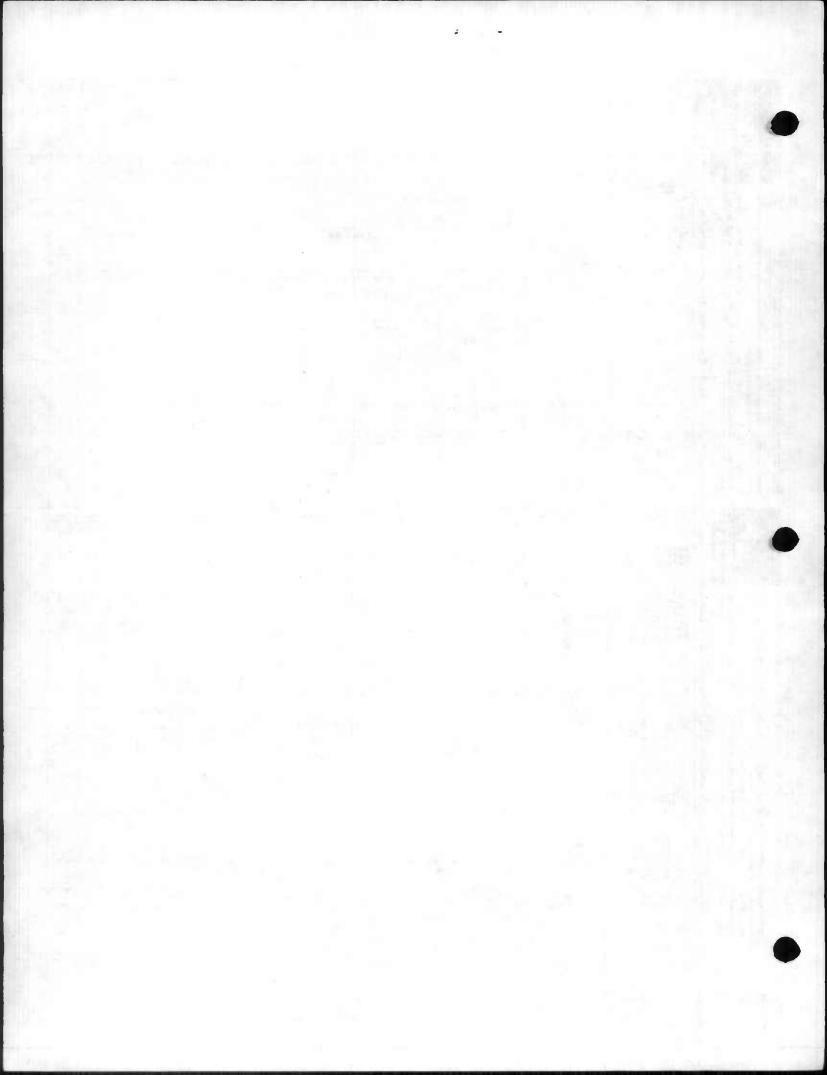
DHMH 16 Rav 6/95

Registrar

TERMS TO THE STATE OF THE STATE

State of Maryland / Department of Health and Mental Hygiene 08510 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey Year Month Physician MYERS MARGARET 2126 21 02 2000 /t/tedical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner MEDICAL BALTIMORE UNIVERSITY OF MARYLAND SYSTEM 7. Age (In yrs. last birthday) If Under 1 Yeer Months Deys Hours Min. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral 10 M 205 54 219-42-8497 Director Maryland Sep. 11,1945 **Usual Residence of Decedent** 10a. State r than "naturel", or items 23s or 28s-f ahow the Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Queen Anne's Centreville Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 412 Railroad Ave. 21617 U.S.A. Funera 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. flied within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Education Teachers Assistant permit. Pages 1 and 2 should be flie
Department of Hasilih end Mental Hy,
Europortant: If Item 27 is marked othe
enty Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 8 Walter Chance Margaret Timms 19a. Informant'a Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) William Robert Myers 412 Railroad Ave., Centreville, Md. 21617 20a. Method of Disposition 20b. Place of Disposition (Name of Dele 20c. Location - City or Town, Stete cemetery, cremetory or other place) Nation | 2 □ Cremetion | 3 □ Removal from State | 4 □ Donation | 5 □ Other (Specify) 25, Feb. 2000 Chesterfield Cemetery Centreville, Md. 21. Signature of Funeral Service License 22. Name end Address of Facility Fellows, Helfenbein & Newnam Funeral Home omas 408 S. Liberty St., Centreville, Md. enter 23a. Peh1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical ELECTRICAL ACTIVIT 15 MIN Examiner Due to (or as a consequence of) HYPERICALEMIA UNKNOWN The lew requires that the death certificate be assouted attending physician and for use as the burlal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eventa resulting in death) Last Due to (or as a consequence of): 68760 ACUTE RENAL TAIWRE UNKNOWN Physician/Medical Due to (or as e consequence of) Box (P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco usa contributa to the cause of death? signed by 1 Yea 2 No 3 Probably 4 Unknown Records. 2 cate has been sig. Completed 24b. Were autopsy findings available prior to 24e. Wes en autopsy completion of cause of death? 1 Yes 2 No 1 Tyes 2 No certificate Vitai al or Attending Physician: Ti s ster death. I Director: After this certificated in by the funeral director, pa 8 25. Was case referred to medical 26. Place of Deeth (Check only one) Yes 2□ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Unpatient 2 ER/Outpatient 3 DOA Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Division 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, atreet, fectory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funerel DI completely filled in edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and titlg.ef certifier 29c. License number 29d. Date signed (Month, Day, Year) P134 02/21/2000 MD **actory** is of person who completed cause of death (Item 23a) (Type, Print) JULIA SHIN JOOYOUN G 31. Date filed (Month, Par Year) 2 3 2000 32. Regilitry's Signature

State Registrar



State of Maryland / Department of Health and Mental Hygiene

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ib			Reg. No.	g. No.									
	Physician	1. Decedent's Name (First, M	liddle, Last) READ MADA		N. E.		2. Dete of D	Day	3. Time of Death 10:00 AM				
/Medical Examiner		CHARLES 4a Facility Name (If not instit		4h City Town	FEB.			10:00 Am					
		25740 VOIT		iniber)			EAS		July 1				
Funeral Director	5. Social Security Number 212–18–9408	6. Sex 1 XX M 2□ F	7. Age (In yrs. 91		If Under 1 Year Months Days	If Under 24 I		rth ay, Year)	9. Birthplace (State or MARYLAND				
١.,	9	Usual Residence of Deceden		7-									
ind 21215-0020 be liled within 72 hours after death vial Hygone. d other than "natural", or itsens 23a	a-f show iffact at	10a. State 10b. Cou	TALBOT	10c. City, Town or Location EASTON					10d. inside City Limi 1 ☐ Yes 2 2 6				
	in with the Ma 23s or 28s-4 s ast be notified al Director	10e. Street and Number 25740 VOIT	ROAD		10f. Zip Code 21601				_	f What Country? JSA			
	by Est	3 XX Vidowed 4 □ Divo	If Yes. Gi	ive	dent Ever in U,S. cas? 13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue case) 1 Yes 2 XXIII Specify:			(Specify Yes or Nuerto Rican, etc.)	o- 14. Ra Ble Speci	ace - American Indian, ack, White, etc. WHITE			
	ed within 72 ho ygene. er then "natur it, the Medical. Completed	15. Dece (Specify only hi Elementary/Secondary (0-1	1-4or 5+)	16a. Deceder (Give kir life. DC FARME	nt's Usual Occu nd of work done O NOT use retire	Business/Indu	idustry						
	Mental Hy whental Hy arked othe affic event, To Be C	17. Father's Name (First, Middle, Last) CHARLES E. MADARY 18. Mother's Neme (First, Middle, Maiden Surname) ELIZABETH READ											
	and 2 sho alth and 27 is ma er treums	19a. Informant's Name/Relationship (Type, Print) CHARLES BOYD MADARY / SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1649, EASTON, MD 21601											
	Pages 1.3 sent of He mt: if flem my or oth	20a. Method of Disposition 1 Burial 2X Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Placa of Disposition (Neme of cemetery, cremefory or other place) CHESAPEAKE CREMATION CTR. 20c. Location - City or Town, State cemetery, cremefory or other place) STEVENSVILLE, MD											
	Departri Departri Importa any inju	21. Signeture of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 S. HARRISON ST., EASTON, MD 21601											
4	Physician /Medical Examiner	23a. Parff. Enter the disease shock, or heart failure. Immediate Ceuse (Final disease or condition resulting in deeth)	i, or complications that clist only one cause on a	RTERIO		OTICCA		WAR DSE			Approximate ntervel Between Onset and Deeth		
68760,	ficate be assecuted physician and is the burial-transit edical Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last	b		r as a conseque				100	1			
Вох	attending for use a	d											
P.0	ed by the detache										the cause of death?		
Records,	aw requisite the second	Con	GESTIVE H	EART F	ALURE 24a. Was an autopsy performed?				avai	24b. Were autopsy findings available prior to completion of cause of death?			
***	certificate ha rector, page	25. Was case referred to med	lical				26. Place of	1 □ Deeth (Check only	Yes 2 No	10	Yes 2□ No		
1	2 00 2	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	ER/Outpatient	3□ DOA Ot	hor:	g Home 5 1 Res		her (Specify)			
ion of	After fune	27. Manner of Death 1 Neturel 5 Per 2 Accident	ading 28a. Dete (Monestigetion	of Injury ith, Day Year)	28b. Time of Injury	28c. Inju Wo M 1	ry at rk?] Yes 2 ☐ No	28d. Describe	how injury occu	rred			
Ö	Paris T		ermined 28e. Place build	e of Injury - At ho ing, etc. (Specify	ome, farm, stree y)	t, factory, offica		281. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Hospital within 24 hours To the Funeral completely filled Medical Co	29a. Certifier 1 Certi (Check only one) 2 Medi	fying Physician: To the cal Examiner: On the b and men	best of my knowasis of examination stated.	wledge, death o tion and/or inves	occurred et the ti stigation, in my	me, date and pl opinion, death o	ace, and due to the courred at the time	cause(s) and n , date and piece	nanner as sta , and due to t	led. he cause(s)		
	withir To th comp	29b. Signature and title of the	illier a			29c. Licen	se number		29d. Date sign	ed (Month, D	ay, Year)		

State Registrar 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

WILLIAM S. BREMER, M.D., 800 S. TALBOT ST., ST. MICHAELS, MD 21663

31. Date filed (Month, Dey, Year) FEB 2 4 32. Registrar's Signature

D26350

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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		Physicia	n	1. Decedent's Name			GHLIN		rimouto o	Douti		Dete of Deeth Month	Day	Year 840 an			
		/Medica Examine		BERTHA J. McLAUGHLIN 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or I										y of Death	المالية المالية		
	3	LAGITIMIC	"	Marin	ner Hea	1th of	Bel A	Air		Be1	Air		Harford				
		Funeral Director								Hrs. 8. 1 Min. 8	Date of Birth (Month, Day, You /20/19	irth 9. Birthplace (State or For Country) /1917 Maryland					
	ы	70		Usuel Residence of	Decedent												
TEST.		death with the Maryland		MD	10b. County Har	ounty 10c. City, Town or Location Harford Whiteford									0d. Inside City Limits 1 ☐ Yes ♣☐No		
		the noth	9	10e. Street and Number 10f. Zip Code								10g	. Citizen of	What Cour	ntry?		
		3a o		1909 Susquehanna Hall Rd. 21160								Ţ	JSA				
Or.		death	Funeral Director	11. Marital Stetus	1		Was Decedent of If Yes, specify C	? (Specify	Yes or No-		ca - Americ						
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M	9	2 hou			15. Decedent's E	ducation		16e. Dece	dent's Usual Oc	cupation		16	b. Kind of I	Business/In	dustry		
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	Baltimore, Maryland 21215-0020	d out	o Be C	17. Father's Neme							Name (Fi	rst, Middle, Ma Boyle		me)			
		d 2 shou th and M 7 la mar traumat		19a. Informent's Ne			4	1 000	ing Address (Stre	eet end Number	or Rural Ro	1 Rd	ity or Town	n, Stete, Zip	code21160		
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		permit. Pages Department of Apportant: If it any injury or of		21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Harkins F.H.Inc., 600 Main St., Delta, PA													
•		Physician /Medicai Examiner		Immediate Ceuse (diseese or condition resulting in death)	nn disame, or cor rt failure. List onl Finel	noli ations that y one cause on	caused the deceach line.	on. Do not on	ter the mode of o	dying, such as ca Covyl	1		l,	7314	Approximate interval Between Onset and Death		
2 CAS	Box 68760,	eath certificate be executed attending physician and I for use as the burial-transit	Physician/Medical Examiner	Sequentially list co if any, leading to in cause. Enter Unde Ceuse (Diseese or that initiated events resulting in deeth) I	nditions, mediate rhying injury Last	· R	Due to	(or as a consector as Consector)	quence af):	lyth	mv	Lus	cycyc				
(0	0 0 0	ysic	Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death?					
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augh		The law requires that the ate has been signed by the page 2 should be datache	Completed by									24a. Wes an a	autopsy od?	/ av	ere autopsy findings relieble prior to empletion of cause death?		
9		ician: The law certificate has rector, page 2	E									1 🗆 Yes	2010	11	☐ Yes 2☐ No		
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ر	Ö	Attending Physician: ordeath. octor: After this certific by the funeral director.	atic	1 Waturel 2 Accident	5 ☐ Pending investigation	on	,,	, injury		Yes 2 □ No							
the	Division	2 # 주 교	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, offica City or Town, Stete)								al Route Number,					
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-		within 24 To the Fu complete	-	29b. Signature and	title of certifier	,	11	h	29c. Lice	ense number	1	29d	. Date sign	ed (Month,	Day, Year)		
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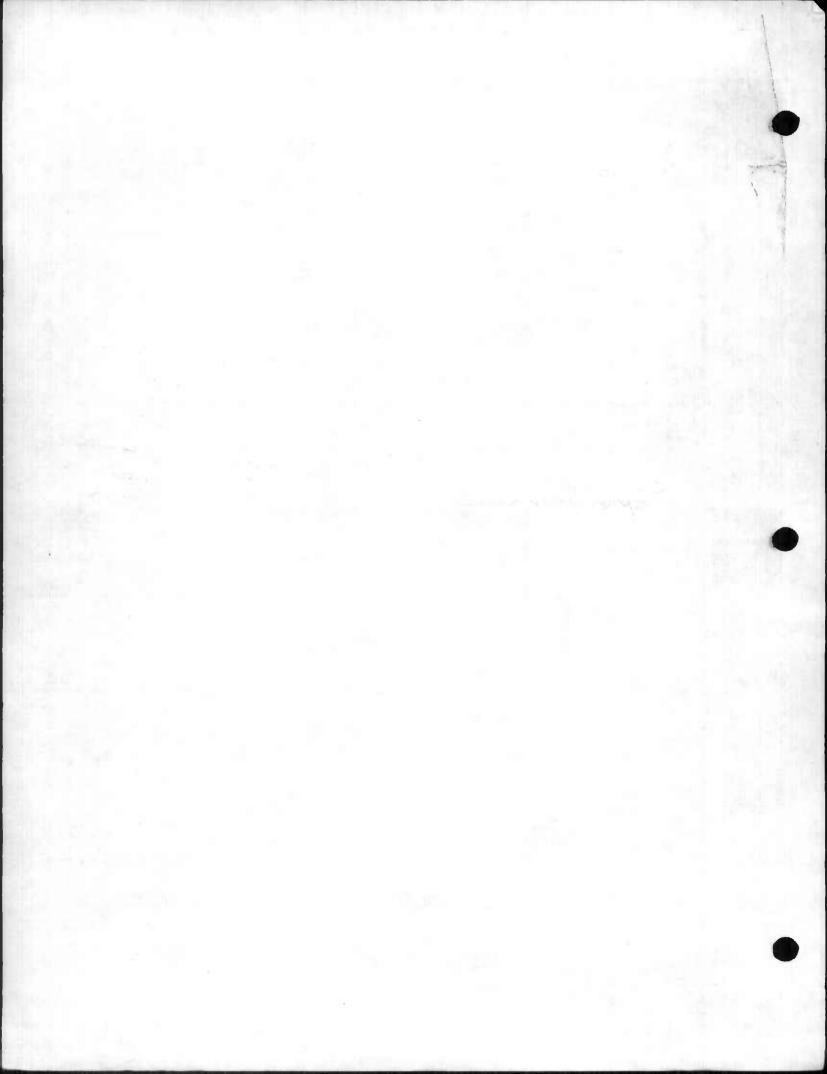
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0705 Maryann Nugent Fc Gruge Y 4b. City, Town, or Localion of Dealh 28 2000 /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** Silver Spring
If Under 24 Hrs. 8. Date of Montgomery 5. Social Security Number 6. Sex If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2\ F 79 Yrs. 066 16 8229 Director Feb. 2, 1921 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic avant, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 8505 Springvale Rd. Nems 23a 20910 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: White Specify: by 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Federal Government Office Clerk la marked other 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be filt.
Department of Health end Mentel Hy
Important: if Item 27 is marked oth
any Injury or other traumatic avant Be George H. Taylor Florence Josephine McNamara 2 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Richard A. Nugent / Son 4740 Connecticut Ave. NW #315, Washington DC 20008 20b. Place of Disposition (Name of 20a. Mathod of Disposition Date 20c. Location - City or Town, Slate Uniform Services 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 2/29/00 4 ☑ Donation 5 ☐ Other (Specify) Bethesda, MD University of Health Sciences 21. Signature of Funeral Rapp Funeral and Cremation Services Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, MD teslet doten 20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or raspiretory arrast, shock, or heert lailure. List only one cause on each line. Approximata Interval Between Onset end Death **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) 1 eymonia days Examiner Due to (or as e consequence of) Examiner that the death certificate be executed Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Physician/Medical the Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by d 1 Yes 2 No 3 Probably 4 Unknown Records, þ Completed 24b. Were autopsy tindings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes 2 No certificate Division of Vital or Attanding Physician: Be 25. Was casa referred to medical examinar? 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending 1 Natural deeth. 1 Yes 2 No To the Hospital or Atlandi within 24 hours after deeth. To the Funeral Director: A completely filled in by the fi 2 Accident investigetion 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signeture end litle of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Joseph & Ball MO D 2331 tebruary 28, 2000 LD 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) JOSEPH BAll 16220 Frederick RUAD Suite 213 Gathersburg MD 20877 31. Date filed (Month, Day, Year) 32. Régistrar's Signature State 2000 MAR 03 Bluer

DHMH 16 Rev 6/95

Registrar

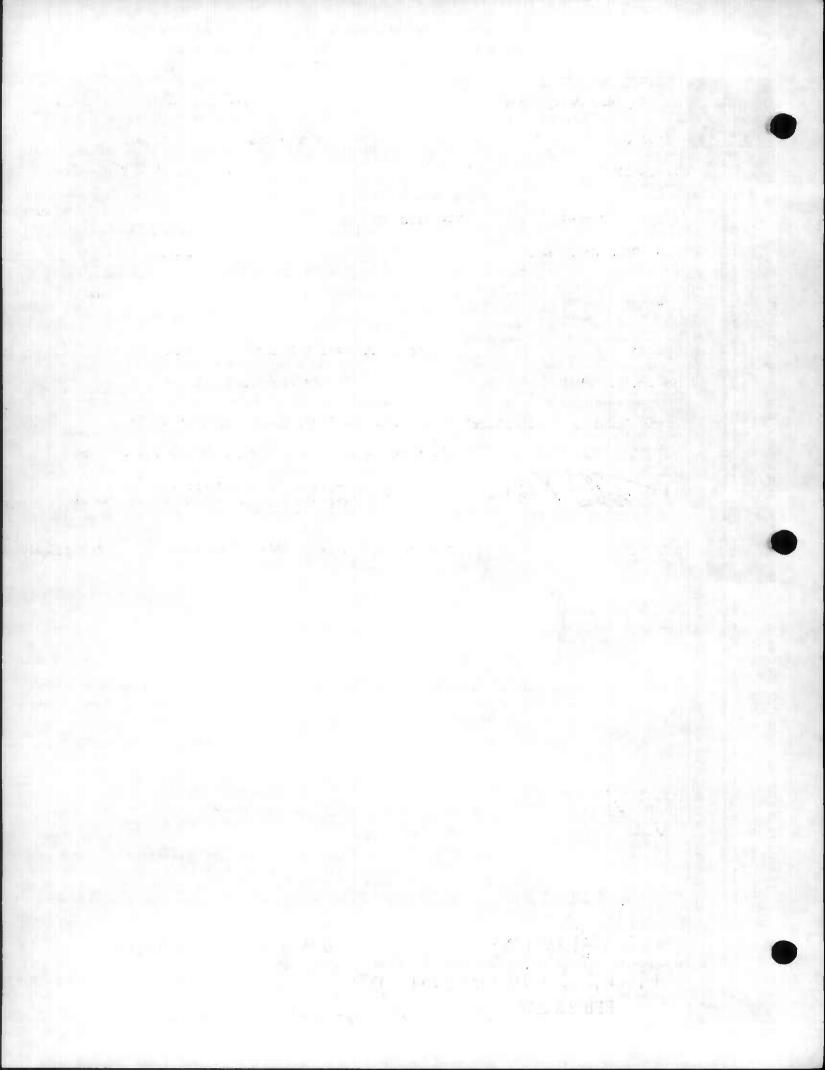
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/Medical	Benjamin Henry Neher								Feb 27			2:20 A						
xaminer	4a Facility Nama (If not institution, giva street and number)							4b. City, Town, or Location of Death 4c. County of Death										
		2801 Sams Creek Rd.							sor	Carrol								
neral ector	5. Social Security Number 577-26-3944 Usuai Rasidanca of Dacadant 6. Sex 1 M 2 F 91 7. Aga (In yrs. last birthday) 4 Months 91						Days	If Undar 24 Hrs Hours Min	Sept. 2	ta of Birth 9. Birthplace (State or Country) t. 24, 1908 Pennsylvan								
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or other	1 3 © E	Burial 2 Cramation							20c. Location - Cliy or Town, Stata									
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important: I any injury o pnce.	21. Signatura of Function 1997 Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 21784																	
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	23a. Part1. Enter the disease, or compilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line.											oproximeta tarvat Batwea						
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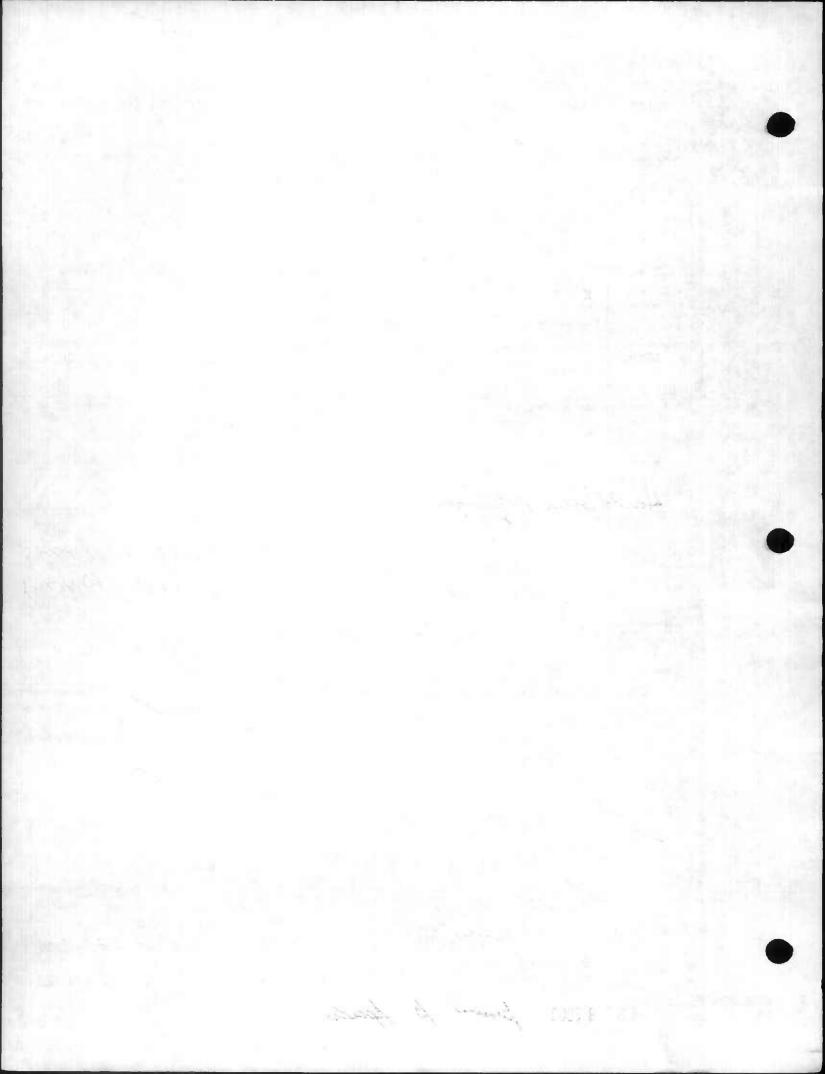
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 0 0 5 5 5

					Ce	rtificate of	Death			Reg. No.				
Physicia /Medic		Decedent's Name (First, Middle ALLEN PARK	2. Dete of Death FEBRUARY 26,2000			3. Tima of Death								
Examin		4a Facility Name (If not institution Sacred Heart Ho	ocation of Deat	4c. County of Death Allegany										
Funeral Director		5. Social Security Number 234–44–6629	6. Sex 1 XM 2 ☐ F	7. Aga (/n y	76 Yrs.	If Under 1 Yas Months Day			8. Data of Bir (Month, Da Sept. 1	th y, Year)	9. Birthp	9. Birthplaca (Stata or Foraign Country) West Virginia		
ahow dall	*	Usual Residence of Decedent 10s. Stata 10b. County WV Mine	era1		City, Town or Lo	ocation				10d. Ins				
death with the Maryle me 23s or 28e-f shor cmust be notified at	Completed by Funeral Director	10e. Street and Number 10f. Zip Coda								1 ☐ Yas 2 💢 No 10g. Citizen of What Country?				
3 44		11. Marital Status 1 Never Merried 25 Marr 3 Widowed 4 Divorced	12. Was Der Armed F ied 1 1 7 Yes if Yes, G	Decedent Evar in U.S. d Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca-Bleck,						ca - Amaric ck, White,	Amarican Indian, White, etc. White			
Maryland 21215-0020 42 should be filed within 72 hours at 12 and Mental hygiene. 12 marked other than "natural", or traumatic event, the Medical Exam		15. Decedent (Specify only highes Elementary/Secondary (0-12) 12th.	it grada completed	(1-4or 5+)	16a. Decedent's Usual Occupation (Giva kind of work dona during mos lifa. DO NOT use retired) Assistant Engineer				king	dustry LC Company				
Viand uld be file Mental Hy, riked othe rific event,	To Be C	17. Fathar's Nama (First, Middla, Allen Anderson					utility company a (First, Middla, Maidan Sumame) Jane Carskadon							
. 5375		19a. Informant's Name/Relations Anna Maxine Nee	BOX 455	drass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) X 455, Keyser, WV. 26726										
Saltimore semit. Pages 1: Separtment of Ha montant. If her my lejury or oth litte.		20a. Method of Disposition 1 M Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nama of camatery, crematory or other place) Potomac Memorial Gardens 2/29/00 Keyser, West											iia	
Certificate be executed from India physician and India physician a	by Physician/Medical Examiner	23a. Part 1. Enter tha disease, or shock, or heart failura. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Undartying Cause (Disease or injury that initiated events rasulting in death) Last Part II. Other significant conditions.	a	Dua to	o (or as a consection of conse	quanca of): RUCTIVI quence of): quence of):	ATONE PUL	MON	FAIL	NRE PISFASI	5	Approximata Interval Between Onset and Deeth B HOUR IN YOUR IN YOUR IN YOUR IN THE COURSE OF T	5	
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or Attanding inter death. Sirector: After in by the fune	Certification:	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 28. Data of Injury (Month. Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yas 2 No 28d. Dascribe how Injury occurred 28d. Dascribe how Injury occurred										al Route Number,		
To the Hospital within 24 hours a To the Funeral Completely filled	edical Ce		g Physician: To th Examiner: On tha i	basis of exam										
To the within To the comple	Mec	29b. Signature and title of certified	ario marinar ataros.				5084	14	29d. Data signed (Month, Day, Year) FEBRUARY 27, 2000					
Juss		30. Nama and addrass of person JOST T. (31. Data filed (Month, Day, Year)	overy	usa of death (. 9	Print) Print)	N DA	wo	5 and	BERCANI	p, ME	21502		



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death 18, 2000 **Physician** IRVIN RAY NEWCOMB February 5:32 A.M. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1204 Georgetown Drive Pel Air Harford If Under 1 Year 5. Social Security Number If Under 24 Hrs. Birthplace (State or Foraign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Funeral 1**3**9 M 2□ F Months | Days Hours Min Yrs. Director 216-18-9002 78 Feb. 14, 1922 Virginia Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2000 Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1204 Georgetown Drive 21014 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Giva Year or Datas: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuben, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 1 ☐ Never Married 2K1 Married 1 ☐ Yes 2 ☑ No Specify: Specify à 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Electrical permit. Pages 1 and 2 should be file Department of Heelith and Mentel Hy Important: if Nem 27 is marked orbit any Injury or other treumatic event, and all 17. Father's Nema (First, Middla, Last) 18. Mother's Neme (First, Middla, Maiden Surnama) Cecil I. Newcomb Carrie Elizabeth Drumheller 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Janice H. Newcomb - Wife 1204 Georgetown Drive, , Maryland Bel Air 21014 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata ©Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 2/22/00 Baltimore, Maryland 21. Signature of Funeral Service License 22. Nama and Addrass of Facility McComas Funeral Home, P.A. Pert 1. Enter the disease, or complication of the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart lailure. List only one author each line. Approximata Interval Batween Onset and Death Physician NON-SMALL CELL LUNG- CANCER /Medical Immediata Causa (Final diseasa or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did lobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown p 24a. Was en autopsy performed? 24b. Wara autopsy findings available prior to completion of cause of death? Completed 1 Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only ona) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Presidence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at tha time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Data signed (Month, Day, Year) rand m.3. FALL STON, MARYE 2 BELAIR ROAD and address of person who completed cause of death (flem 23a) (Type, Print) 31. Date filed (Month, Day, Year) FEB 22 32. Pégistrar's Signatura

State Registrar

7 is marked other than "natural", or items 23s or 28s-f show treumstic event, its Medical Examinal mast be notified at

physicien and the buriel-transit

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To the Hospital or Atta within 24 hours eiter de To the Funeral Direct completely filled in by t

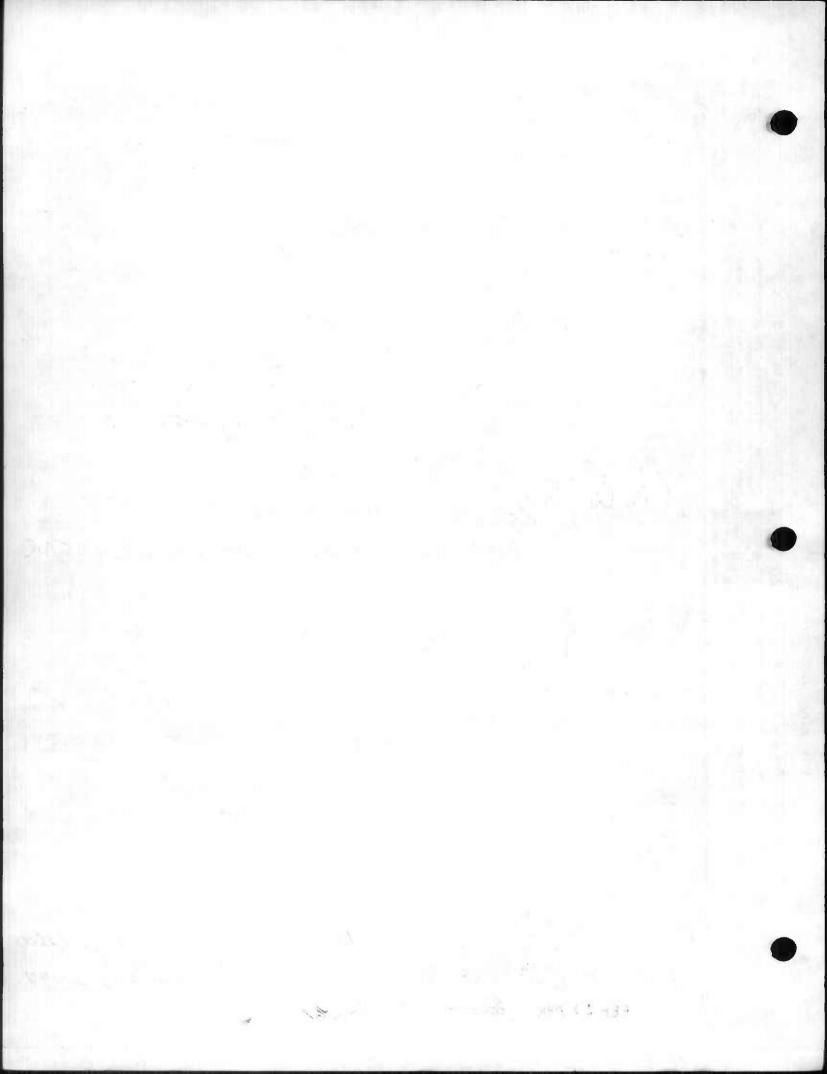
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Director: A

e filed within 72 hours efter of Hygiene. other than "natural", or item

Saltimore, Maryland 21215-0020

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2000 Month O'Neal Robert N. 28, 1:00 AM Feb. 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Montgomery Kensington 9620 Culver St. 8. Date of Birth (Month, Day, Year) 9. Birthplace (Stelle or Foreign Quarthy) 4. Aug. 23, 1930 Washington, D.C. 6. Sex 1 2 M 2 ☐ F If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Days Hours Yrs. 69 578-36-7024 Uaual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Maryland Kensington Montgomery 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20895 9620 Culver Street 13. Was Dacedent of HIspanic Origin? (Specify Yea or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Yea 2 No If Yas, Give Yaar or Dates: 1 Never Married 2 Married Specify: White 1 Yas 2 No 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Securities/Finance Stock Broker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Evelvn Payne Nelson Blondel O'Neal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9620 Culver Street, Kensington, Md. 20895 Amy R. O'Neal -daughter 20a. Mathod of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State 3/6/2000 Falls Church, Va. 4 Donation 5 Other (Specify) National Crematory 22. Name and Address of Facility Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW. Washington, DC. 20016 23a. Part1. Enter the diversion shock, or heart failure ise, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, List only one cause on each line. Approximate interval 5 Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in deeth) Respiratory Arrest Due to (or as a consequence of) Carcinoma of Prostate 3 Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Metastatic Carcinoma 2 Years Dua fo (or as a consequence of): Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Obstructive Lung Disease 24b. Were autopsy findings available prior fo completion of cause of death? 24a. Waa an autopsy Pneumothorax 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case refarred to medical 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Nesidenca 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 1 Natural 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

7 ie marked other than "natural", or itema 23a or 28a-f show traumatic event, tra Meurcal Examiner naist de notitied al

I Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 ie marked oth any Injury or other treumatic event

the Maryland

death

72 hours after

Saltimore, Maryland 21215-0020

Box 68760

P.O.

Division of Vital Records.

Examine sician and burial-trans attending physician for use as the buria ian/Medical detached the signed by 8 page 2 certificate has

After this I or Attending P after death. Director: After t

Physic P Completed Be OL

edical

2 Accident 3 Suicida

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29b. Signatura and title of contitier

29a. Certifier (Check only one)

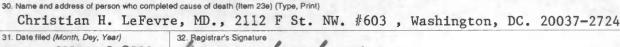
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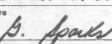
Registrar

31. Date filed (Month, Dey, Year) MAR 02 2000

5 Pending investigation

6 ☐ Could not be





28c. fnjury at Work?

11x Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) end manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and grapher stated.

29c. License number DC10731

1 Yes 2 No

28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)

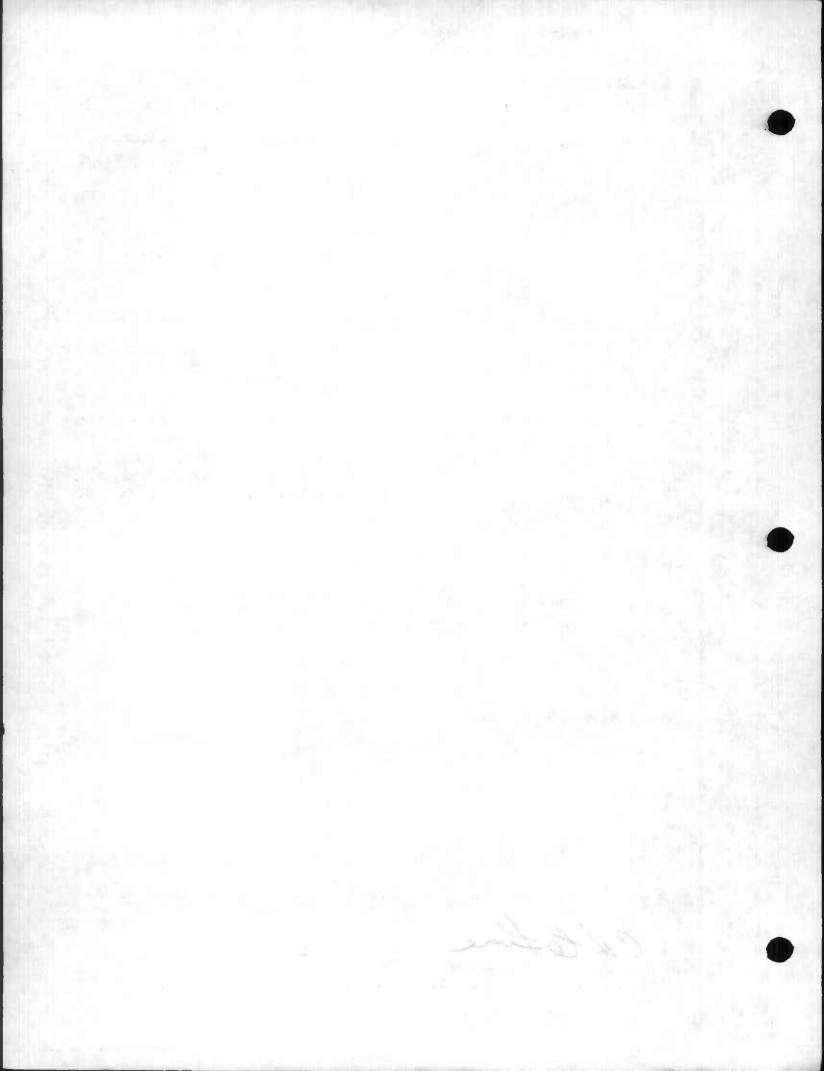
March 1, 2000

29d. Dafa signed (Month, Day, Year)

DHMH 16 Rev 6/95

28b. Time of

28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death "LEARY Month **Physician** ALLEN EDWIN FEBRUARY 17 2000 02:21 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE CITY THE JOHNS HOPKINS HOSPITAL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Deys Hours 1MM 2□ F Yrs. Director 73 111-20-3203 Jan. 6, 1927 New York Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Directo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pagas 1 and 2 should be filed within 72 hours efter death with naml of Heelih and Mertel hygiena.

Att if item 27 is marked other than "natural", or from 23e or into other traumed overly. It western the market in yor other traumed overly. It westerns 622 Lee Way 21014 USA Funeral 11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Never Married 20 Merried 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: ₩₩∏ Maryland 21215-0020 1 Yes 2√ No Specify: Specify: p 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) (u/k)Max O'Leary Caroline (u/k)Stephenson 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Elizabeth Jane O'Leary / Wife te 622 Lee Way, Bel Air, MD 21014
20b. Place of Disposition (Name of cemetery, cremetory or other place)

Dete 20c Baltlmore, 20a. Method of Disposition 20c. Location - City or Town, Steta 1 Burial 2 □ Cremation 3 □ Removel from State permit. Page Department of Important: If any injury or page. 4 Donation 5 Mother (Specify) ENTOMEMENTBel Air Memorial Gardens 2-21-00 Bel Air, Maryland 22 Neme and Address of Facility
MCComas Funeral Home, P.A. 23a. Part1. Enter me dishese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart hands. List only one cause on each line. 1317 Cokesbury Raod, Abingdon, Maryland 21009 Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical CARDIOMYCRATHY TWO WEEKS Examiner Due to (or as e consequence of): Physician/Medical Examin physician and the burlei-transit The law requires that the death certificate be assected Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760, Due to (or es e consequence of) 088 signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. of Vital Records, P.O. 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Was an eutopsy Completed paga 2 After this certificate has 1□ Yes 2200 1 Yes 2 No Physician: after death.

Director: After this certific d in by the funeral director. 25. Was case referred to medical examiner? 8 26. Placa of Deeth (Check only one) Hospital: 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 26d. Describe how injury occurred 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation Division or Attanding Natural 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Hospital 24 hours Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and manner steted. 29a. Certifie adical completely (Check only one) within 2 95 29d. Dete aigned (Month, Day, Year) 29b. Signature and title of certifier 29c. License number DR. R.A. WATSON RES 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) WATSON, JOHNS HOPKINS HOSPITAL, NORTH WOLFE STREET

DHMH 16 Rev 6/95

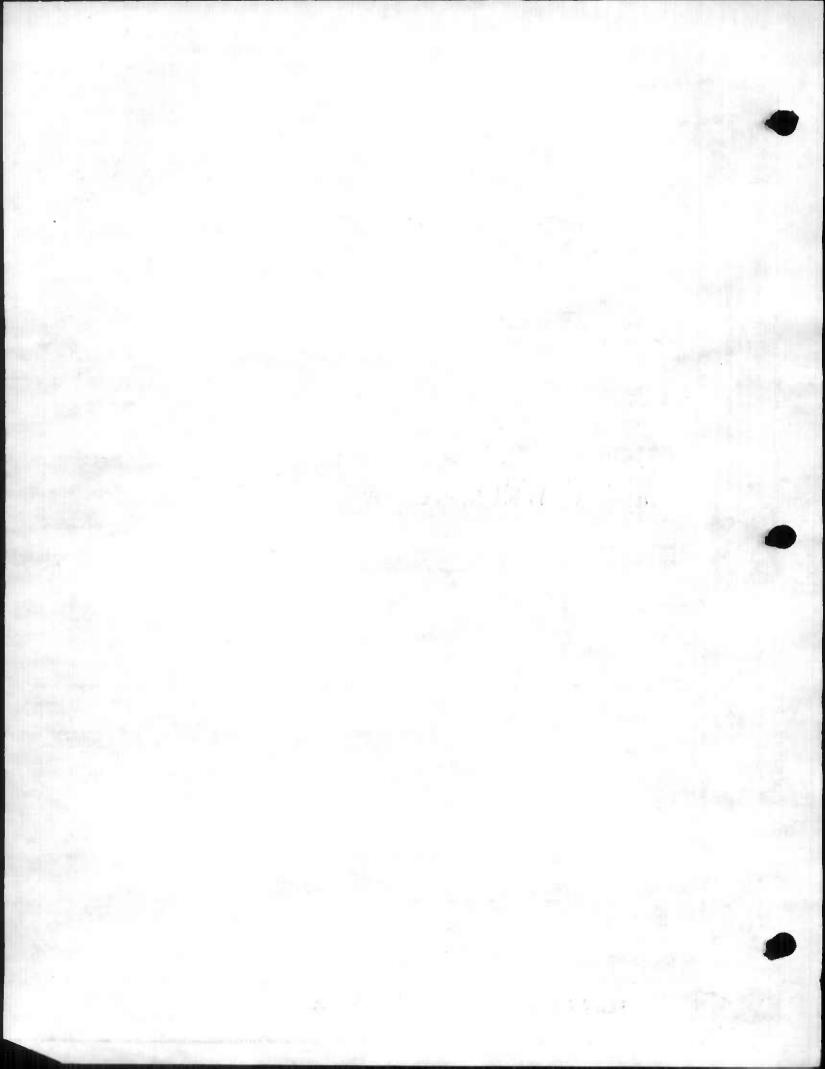
State

Registrar

31. Date filed (Month, Day, Year) FEB 22

32. Registrer's Signature

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Mary Irene Peacock 27, 2000 3:15 AM February /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner Manor Care-Potomac Potomac Montgomery If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year)
NOV. 24, 1 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 □ M 2 🖾 F 93 Yre 1906 Director Poland 028-28-0368 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Insida City Limits 10b. County 1 Yas 2 □ No Director Middlesex Melrose Mass. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 910 Main Street 02176 United States Funeral 13. Was Decedent of Hispanic Origin? (Spacify Yas or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ◯XNo 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: Specify: Completed by 3 XWidowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Sherwin Williams Elementary/Secondary (0-12) College (1-4or 5+) Paint Company 4 Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paulina Vankowska Edmund Urbankiewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Heelth and Important: If Item 27 Is in any Injury or other traun pings. 3 Buttonwood Lane, Bethesda, Maryland 20816 Carol Einaudi/ Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata March 2, 1 Burial 2 □ Cremation 3 □ Removal from State Stoneham, 4 ☐ Donation 5 ☐ Other (Specify) Lindenwood Cemetery 2000 Massachusetts 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda-Chevy Chase, Inc. 7557 Bethesda, Maryland 20814-3501 M00689 Approximate Intarval Between Onset and Death disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failura. List only one cause on each line. **Physician** /Medical Immediate Cause (Final PNEUMONIA 2 MONTHS disease or condition resulting in death) Examiner Physician/Medical Examiner Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Diseasa or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Dua to (or as a consaguance of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown à 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Tes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at 4 Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicida

The law requires that the death certificate be executed use as the bunal-tran pue Box 68760, attending physician page 2 should be detached for P.O. yd bengis of Vital Records, After this certificate has spital or Attending Physician: Theors after death.

neral Director: After this certificate filled in by the funeral director, ps Division

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d 2 should be filed within 72 hours after death with the Maryla. It and Mental Hygiene.
7 Is marked other two "natural", or itema 23a or 28af ahov traumnito event, in abode it and matural in the continual or th

Maryland 21215-0020

Baltimore,

To the Hospital o within 24 hours af To the Funeral DI completely filled is

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Cristing Shomasmo 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print)

KRISTINE. THOMAS, MD 3301 NEW MERICO AVE. NW SUITE 348 WASHINGTOND WOOD

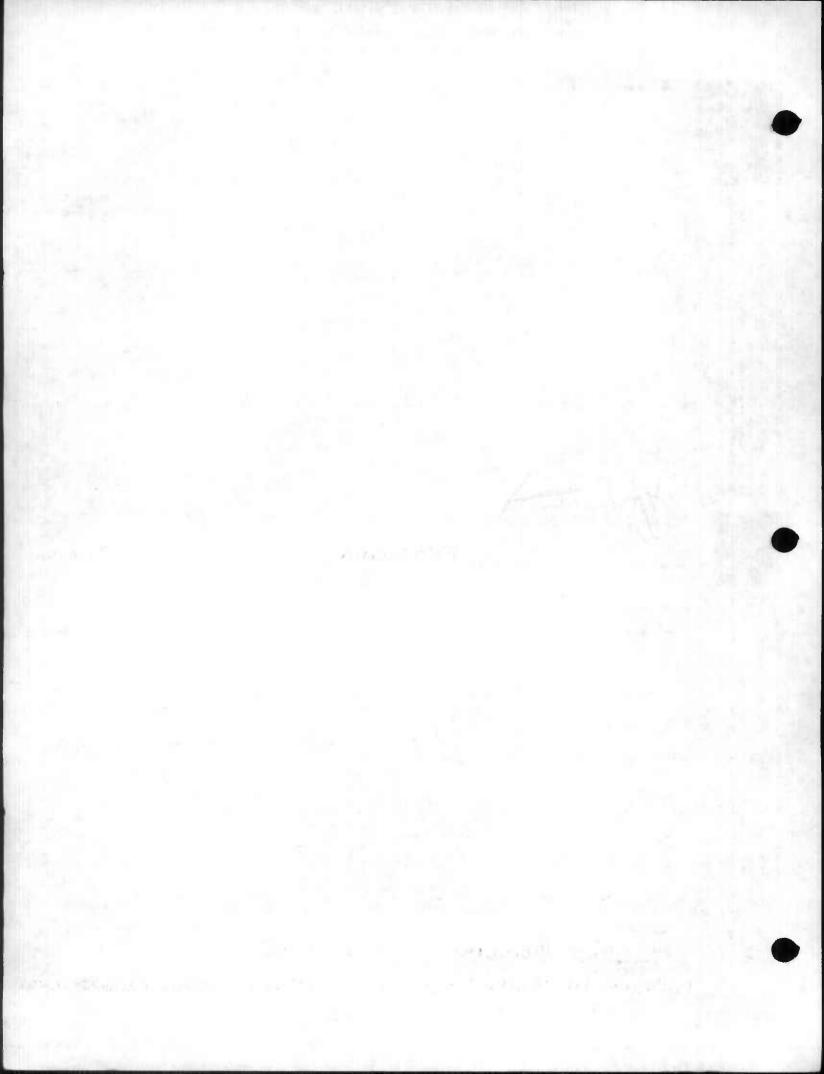
February 28, 2000

· State Registrar

31. Date filed (Month, Day, Year)

4 Homicide

MAR 01 2000 32. Registrar's Signatura



Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year Robert Andrew Peternell, Sr. February 24, 2000 8:30 PM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, giva streat end number) 4c. County of Death Montgomery Bethesda Suburban Hospital 8. Data of Birth (Month, Dey, Year) 1920 If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) 15 M 2 F Months Days Hours 79 Yrs. Minnesota 578-32-4068 Usual Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits Maryland Montgomery Bethesda 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10031 Sinnott Drive 20817 United States 12. Was Decedant Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No WW II If Yes, Give Yeer or Dates: Was Dacedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - Amarican Indian Black, White, etc. 1 Never Marriad 2 Married 1 Yes 2 No Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) U.S. Department Elementery/Secondary (0-12) College (1-4or 5+) of Navy Architect 4 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surneme) Anna Bier Andrew Peternell 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Coda) 19e. Informant's Name/Relationship (Type, Print) 10031 Sinnott Drive, Bethesda, Maryland 20817 Jennie T. Peternell/ Wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Feb. 29, 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stete Silver Spring, 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2000 Maryland 22. Nama and Address of FacilityRobert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, lailure. List only one cause on each line. Approximete Interval Between Onsel and Death RESPIRATORY FAILURE Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es a consequence of): 23b. Did tobacco use contribute to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yss 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Wes en eutopsy performed? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 EP/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred

Physician /Medical Examine

Physician

Examiner

Funeral

Director

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Department of Important: If any injury or page. 5 %

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Pages 1 and 2 should be filled within 72 hours aftar death nent of Health and Mental Hygiene.

Hygiene.

altimore, Maryland 21215-0020

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Examiner Physician/Medicai

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that the death certificate be axecuted death. rector: Direc 9 24 hours aft Funeral Di letely filled in

eternell, Robert

To the Hosp within 24 ho To the Fune completely fi 25+

Medicai 29b. Signature and title of certified

5 Pending investigation

6 Could not be determined

and manner stated.

28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

29c. Licansa number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete and place, end dua to the cause(s) 29d. Data signed (Month, Dey, Year)

28f. Location (Streat and Number or Rural Route Number, City or Town, Stete)

30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

Elliot R. Goldstein, M.D. 9410 Old Georgetown Road, Bethesda, Maryland 20814-1700

31. Date filed (Month, Day, Year) FEB 2 8 2000 Registrar

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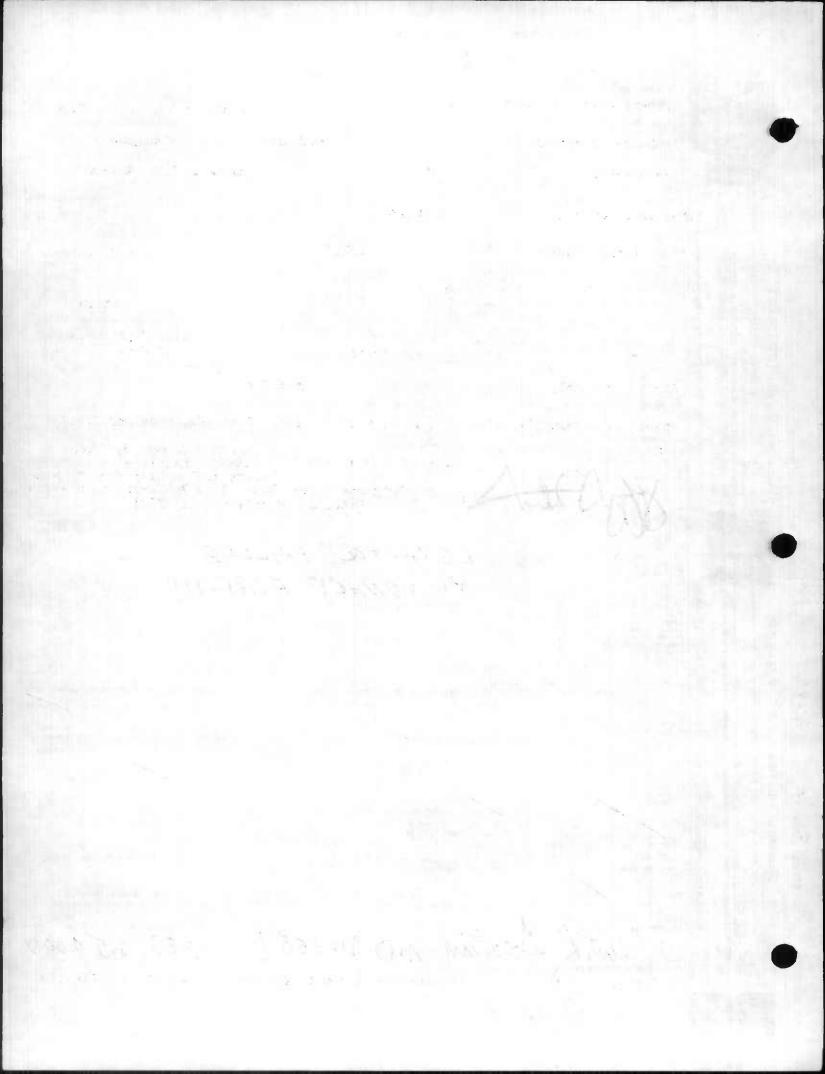
2 Accident

3 Suicida

29a. Certifier (Check only one)

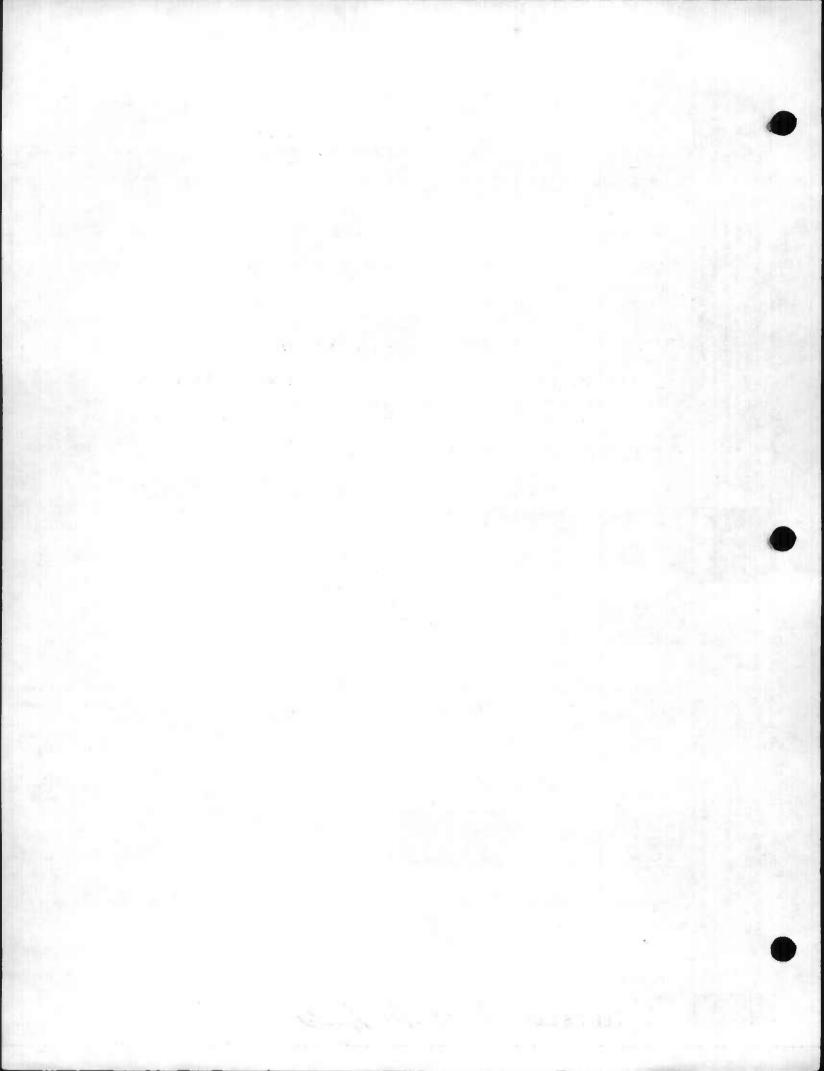
4 Homicide

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

	C	ertificate of Death	Reg. No.	00021
Physician /Medical		oN	Date of Death Month Day Year Corvey 24 205	3. Time of Death
Examiner	de Freille, blance (Ment lestitution miss attende au de contra et	4b. City, Town, or Locs COLUMBIA		WARD
Funeral Director	5. Social Security Number 213–20–3968 6. Sex 1□ M 2☒ F 7. Aga (In yrs. last birthda 77 Yrs.	If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min. I	(Month, Day, Year) Co.	hplaca (Stata or Foreign untry) RYLAND
e Maryland la-f show tilled at	Usuat Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or MD HOWARD	Location DAYTON		10d. Insida City Limits 1 ☐ Yes 2 🌠 No
th with the Maryla 23a or 23a-f sho ust be notified at		10f. Zip Code 21036	10g. Citizen of What Co U.S	
0020 surs after death raf, or llama 23 Examinet must	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Evar in U,S. Armed Forces? 1 Yas 2 No HYS, Giva Yaar or Dates:	 Was Decedent of Hispanic Origin? (Specifi Yes, specify Cuban, Mexican, Puerto Ri 1 ☐ Yas 2 No Specify: 	fy Yas or No- can, atc.) 14. Race - Ama Black, White Specify: WH	9, etc.
21215-0020 d within 72 hours at glere. the Medical Exam commissed by 1	(Specify only highest grada completed) (Gi	cedent's Usuat Occupation va kind of work dona during most of working i. DO NOT usa retired)	16b. Kind of Businass/I	Industry
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/land	17. Father's Nama (First, Middle, Last)		First, Middla, Maiden Sumame) LILLIAN AKEHURST	
, Mary and 2 sho saith and 3 n 27 is ma ar trauma	19a. fnformant's Name/Retationship (Type, Print) MR. WALTER J. PATTERSON (SPOUSE) 14	illing Addrass (Street and Number or Rural II 118 HOWARD ROAD DAYIN		Zip Code)
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Ball permit Depart Import any in	21. Signature of Funaral Sarvice Licensee Buan X. Haylt	22. Name and Address of Facility HAIGHT FUNERAL HOME SYKESVILLE, MD 2178	& CHAPEL (BOX 19 4 (410)-795-1400	5)
	23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.			Approximata Interval Batween Onset and Death
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To the vithing to the composition of the compositio	29b. Signature and title of femiliar	29c. Licansa number D. 3046 9	29d. Data signed (Month	h, Day, Year) 24, 2000
	30. Name and address of person who completed cause of death (flem 23a) (Typ N° & VELLANCE, TOSS, CHEVROLE	2 Print) De 've: #10	o, Ethielt city	. MD. 21042
State Registrar	FEB 2 8 2000 32. Registrar's Signatura	5. Looks		



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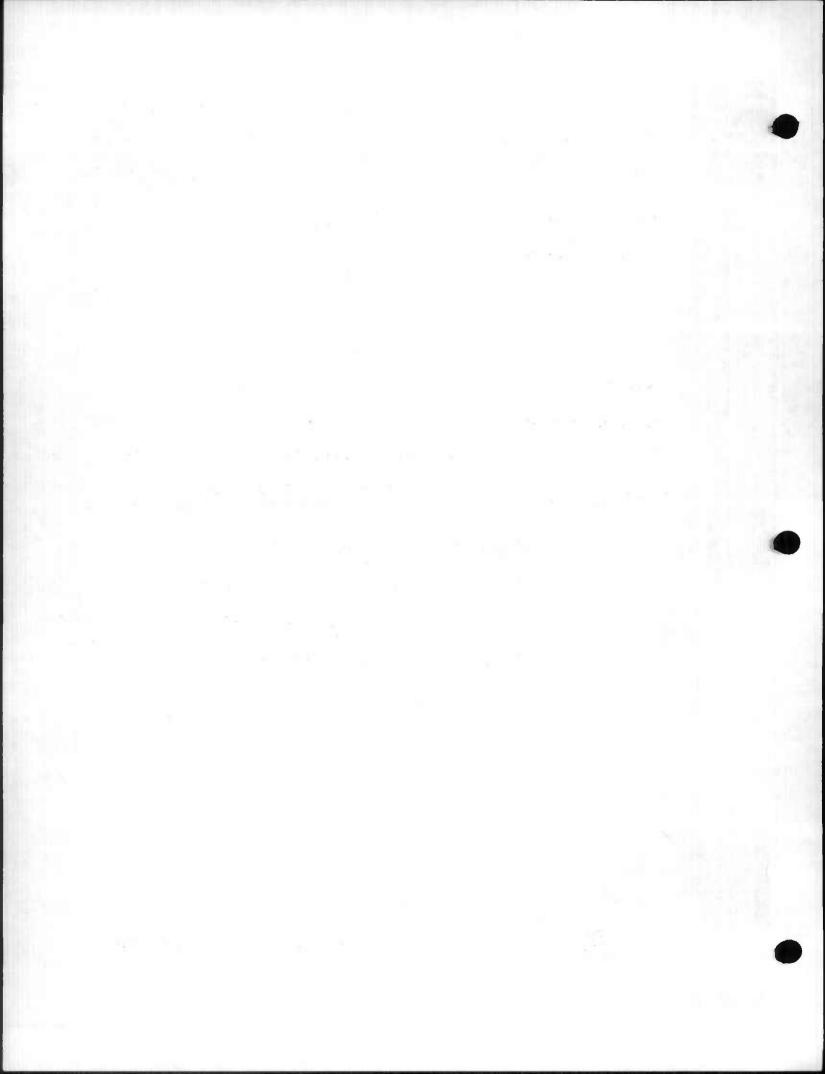
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		Mallard Bay Care	Center					ambr	idge	Do	rches	ter	
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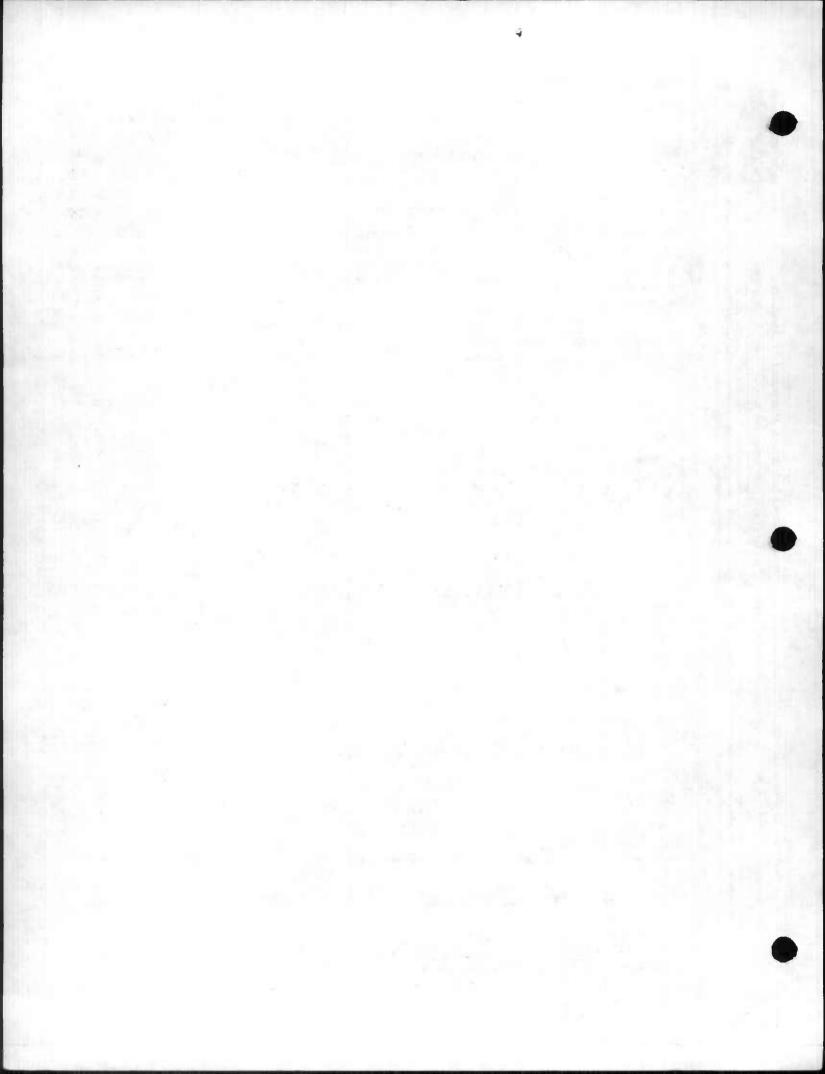
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	/Medic Examin		4e Facility Nama (II not institutio						4b. City, Town, or L		4c. County			
7	CAGIIII	C.	2 WILLOW COUR					S	TEVENSVII	LE	QUEE	N ANNE		
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	Director		214-30-1442	1□M 2ÅF	66		Yrs.	Months Deys	Hours Min.	8. Data of Birth (Month, Dey, MAR • 18	, 1933	MARY I	a (State or Foreign LAND	
	_		Usual Residence of Decedent							.1				
	ahow		10a. Stete 10b. County			10c. City, Town						10d	. Inside City Limits	
	Me La	50	MD QUE	EN ANNE		STEVE	INSV	TLLE					1 No 2 No	
	or 28a-f	Director	10e. Street and Number					10f. Zip Code	8 = 1	10	g. Citizen of	What Country	7	
	death with the Meryland THS 23a or 28a-f ahow	alD	2 WILLOW COU	RT				21	666	15.1	US	A		
		Funeral	11. Maritel Stetus	12. Was De	cedent	Evar in U,S.	13. V	Ves Decedent of H	Hispanic Origin? (Sp an, Mexican, Puarto	pecify Yes or No-		e - American		
0	or he		1 Nevar Married 2 Mar		24	No				rican, etc.)		ck, White, etc		
70	le le	b	3 X Widowed 4 ☐ Divorced	If Yes, G Yeer or				☐ Yes 21X No	Specify:		Specify	v: WH	IITE	
2	72 ho	ted		it's Education st grade completed	n	16e.	Deced	ent's Usual Occup	oation during most of work d)	ring 1	6b. Kind of B	usiness/Indus	stry	
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	E SE	Be Completed	17. Fether's Nema (First, Middla,	Last)					18. Mother's Nem	e (First, Middle, N	laiden Surnan	ne)		
ya Ya	Ment	2	JOHN J. MILES						BEATRI	CE ROSE H	UGHES			
a	and and series		19a. Informant's Neme/Reletions								-	or Town, State, Zip Code)		
2	and n 27		MICHAEL PARKE	R / SON					T, STEVEN	SVILLE,	MD 216	66		
Ore	f of H		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cramation	3 Removal from	n Stete	cematar	y, cran	sition (Name of netory or other ple			Oc. Location		n, State	
	nit. Page: artment of ortant: If I Injury or B.		4 Donetion 5 Other (S			CHESAPE	SAKE	CREMATI	ON CTR.	2-26-00	CHESTE	R, MD		
Daltill	permit. Page Department of Important: If any Injury of phos.		21. Signature of Funeral Service	: 45	he		FE 10	6 SHAMRO	ELFENBEIN	CHESTER.	MD 21	619		
	Physician /Medical		23a Part1 Enter the disease, or shock, or heart failure. List		st,	; In	pproximete iterval Between inset and Death							
	Examiner		disease or condition resulting in deeth)	ailure			6-7 mon-							
	1.0	-			Due to (or as e consequenca of):						1	ore than		
	nsit ned	는		₽ b Û]	ar	2115	IV	ellite	15			10	years.	
	ate be executed ysician and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury			Due to (or es e d	conseq	uenca of):						
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5	the d	ysi	Part II. Other significant condition	ven in Pert I.		1		he cause of death?						
L	deta deta		Septicos	nia						1 Y	2 No	3 Probal	bly 4 Unknown	
cords,	w requires that the death certifice toest signed by the attending phe should be detached for use as the	Completed by	Coronar	mary Artery Disease							autopsy ned?	aveila	eutopsy findings able prior to pletion of cause ath?	
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	Physician: The lav this certificete hes el director, page 2		25. Wes case referred to medica						OS Plans of Dan		, ,	'0'	162 5 140	
>	Cent	o Be	axaminer?	Hospital:] Inpatio	0□ ED/O		t 3 DOA Oth	201	th (Check only one		(6		
5 ;	Phy reld	-	27. Menner of Death	28a. Dete	e of Inju	ry 28b. T	ime of	28c. Inju		ome 5 Reside 28d. Describe ho				
5	Affe Affe	5	1 XNatural 5 ☐ Pendir 2 ☐ Accident investi	ng (Mo	nth, De		njury		rk? Yes 2 □ No					
DIVISION	or Attanding Physician: after death. Director: After this certific I in by the funerel director,	Certification:	3 Suicide 6 Could 4 Homicide determ	not be 28e. Pled		ury - At home, fer c. (Specify)	rm, stre	eet, fectory, office		28f. Location (Str City or Town		ber or Rural F	Route Number,	
	To the Indeptal or Atlanding Physician: The is within 24 hours after death. To the Funeral Diffector: After this certificate he completely filled in by the funeral director, page	edical C			basis o	axamination end			me, date and placa, opinion, death occur					
:	Within To the	Me	29b. Signature and title of certifie		-		2201	29c. Licens	se number	25	d. Date signe	d (Month, Da	y, Year)	

State Registrar

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

LAWRENCE D. BOHAN, M.D., 505 DUTCHMAN'S LANE, EASTON, MD 21601

D27409



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth February 20, Zooo 6:18 AM Poole Norman c. County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) Baltimore Samaritar If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Months Deys 100 M 20 F Yrs. 20, 1929 Massachusetts 023-20-4112 70 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Edgewood 10g. Citizen of What Country? 10e. Street end Number 10f. Zip Code 2231 Rosewood Drive 21040 USA 14. Race - American Indian. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. 1X Yes 2 No If Yes, Give Year or Dates: WW II 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) Quality Assurance Officer U.S. Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Harold Poole (nmn) Vaneil Thomas Doris 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Liselotte Poole - Wife 2231 Rosewood Drive, Edgewood, Maryland 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete Burial 2 Cremation 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Bel Air Memorial Grdns. 2/24/00 Bel Air, Maryland 22. Name end Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, MD 21009 e, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, List only one ceuse on each line. Approximete Intervei Between Onset and Death Immediate Ceuse (Finel 9 weeks Stroke diseese or condition resulting in deeth) Due to (or es e consequence of): Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es a consequenca of): Due to (or es e consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy 1 P Yes 2 No 1 Tyes 2 No 25. Was cese referred to medical 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

Physician

' /Medical

Examiner

Director

Funeral

þ

Completed

Be

2

Funeral

Director

item 27 is marked other than "natural", or itams 23a or 28a-1 show other traumatic event, the Medical Examinar must be notified at

end Mantai Hygiene.

parmit. Pages 1 and 2 should be file Department of Health end Mantat Hy important: If Item 27 is marked other any injury or other traumatic event

altimore, Maryland 21215-0020

Examiner Physician/Medical 2 Completed Be 2 Certification:

examiner? 1 Yes 2 No

27. Menner of Deeth

1 Neturel

2 Accident

3 Suicide

29a. Certifier

4 Homicide

31. Dete filed (Month, I

the buriel-transit pue physician 90 USO BS attending signed by the a should ! certificate director, funeral Hospital or Attending F 24 hours after death. Funeral Director: After To the Hospital or Atte within 24 hours after de To the Funeral Directo completaly filled in by the

P.O. Box 68760

Division of Vital

State

edicai

29b. Signature and title of certifier end eddress of pe ERR.

5 Pending

Investigetion

6 Could not be

29c. License number

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

son who completed cause of deeth (Hem 23e) (Type, Print) 10 North Greene Street CoLVIN Baltimore, Maryland

4000

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA

28b. Time of

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28e. Dete of Injury (Month, Dey Year)

32. Registrar's Signeture

1 Yes 2 No

Registrar

WATER SELECTION OF ACM TO SECURE STATE OF THE PARTY OF THE PART Idiy on markey a section THE PERSON OF TH With the best of the second state of the second state of the BOOK TOWN SO LAND CAPPER SO THE PERSON

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 08525 Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 10:46, **Physician** 25,2000 FEBRUARY Hildegard R. Reiser /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** AUREL PRINCE GUORGES LAUREL REGIONAL HOSPITAL If Under 1 Year 8. Date of Birth (Month, Dey, Year) Nov. 25, 1919 if Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) Birthplace (State or Foreign
Country) 6 Sev **Funeral** Deys Months Hours Min 10M 200 80 Yrs. 316-66-0334 Germany Director Usual Rasidence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itsems 23s or 28s-f shot traumatic event, the Medical Examine, must be notified at 1 ☐ Yes 21 No Beltsville Prince George's Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11308 Cedar Lane 20705 Germany Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11 Maritel Status Bleck, White, etc 1 Never Married 2 Married 1 Yes 2 No White Baltimore, Maryland 21215-0020 Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Hygiene. College (1-4or 5+) Elemantary/Secondary (0-12) Registered Nurse Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) mit. Pages t and 2 should be file partment of Health and Mental Hy portant: If Item 27 is marked other y Injury or other traumatic event Be Klein Josef Ziegler Maria 19a. Informent's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Sheldon Reiser (husband) same as #10 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 1 ☐ Buriei 2 XX remetion 3 ☐ Removel from State permit. Page Department o Important: If I Metropolitan Crematory 2/28/2000 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatime of Funeral Sarvice Licensee 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Md. 20705 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or haert failura. List only ona causa on each line. Approximata Interval Between Onset end Deeth **Physician** · ARTORIOSCUEPOTIC CARDIOVASCULAR DISEASE /Medical immediate Causa (Final disease or condition resulting in deeth) Examiner Dua to (or es a consequança of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that Initiated evants resulting in death) Lest Dua to (or as a consequence of): pue bunial-tran certificete be exe physician e Box 68760 Physician/Medical Due to (or as e consequence of): 98 esn 0 23b. Did tobacco use contributs to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. the 3 1 Yes 2 No 3 Probably 4 Unknown signed t Records, by 24b. Wera eutopsy findings evailable prior to completion of cause of daeth? 24a. Was en autopsy Completed peen paga 2 1 Yes 20 No 2 No 1 ☐ Yes certificata Division of Vital Hospital or Attending Physician: director. 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) examiner? 1 XYes 2 □ No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Rasidance 8 Othar (Specify) 2 this funerei 27. Manner of Deeth 28a. Date of injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. injury et Work? Affer 5 Pending investigation 1 Watural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homicida 24 hours 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. edical 29a. Cartifier (Check only one) To the To the To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 5 FEBRUARY 28, 2000 th (Itam 23e) (Type, Print)

MO

32. Begistrar's Signature

3001

HOSPITAL

DRIVE CHEVERLY

MARYLAND 20785

State Registrar MAN216 GOLD
31. Date filed (Month, Day, Year)

MAR 0

2000

. 10.20

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Edmondo P. Ricoy 4a Facility Name (If not institution, give street end number) February 24, 2000 5:00 pm 4c. County of Death 4b. City, Town, or Location of Death Millenium Health and Renab Centerat South Riur Edgewat 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) II Under 1 Year II Under 24 Hrs. Anne Arunde 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) MCXICO 6. Sex 100 M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) Deys Hours 578-68-2200 August 0a, 190 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Anne Arunde 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Plain 421 AVCNUL 21037 1.5.A Was Decedent Ever In U,S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: MCXICAN Yes 2 No Specify: HISDANIC 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Linguistics Interpreter 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Marcello 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Mercersburg PA RICOU Hunter Road Ezequiel 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Anatomic 61ft Foundation 2/25/100 Caurel, MD 4 Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Facility Anatomic GIFT Foundation 13948 Baltimur Avenue Laur 1 MD 20707 Approximate tntervel Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or feart teilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) RENAL FAILURE 2 WEEKS more than month Due to (or es e consequença of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DIABETS 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? DEMENTIA 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

Physician /Medical Examiner

The law requires that the death certificate be axecuted

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner

by

Be Completed

edicai Certification: To

permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygient Important: If them 27 is marked other the may injury or other traumatic avent, the page.

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23s or 28s-f show

Funeral Director

Completed by

other traumatic avant, the Medical Examiner must be notified at

filed within 72 hours after

Baitimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Lest

27. Manner of Death

Natural
Accident

3 ☐ Sulcide

29a, Certifier

4 Homicide

1 | Inpatient 2 | ER/Outpatient 3 | DOA

28e. Dete of Injury (Month, Dey Year) 5 Panding investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, end due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end menner stated. 29b. Signature end title of penifier

29c. License number D 50653 29d. Date signed (Month, Dey, Year) 02-25-2000

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Dealechunchton 5851 -

GYAN CHAND

SURANIA 20751

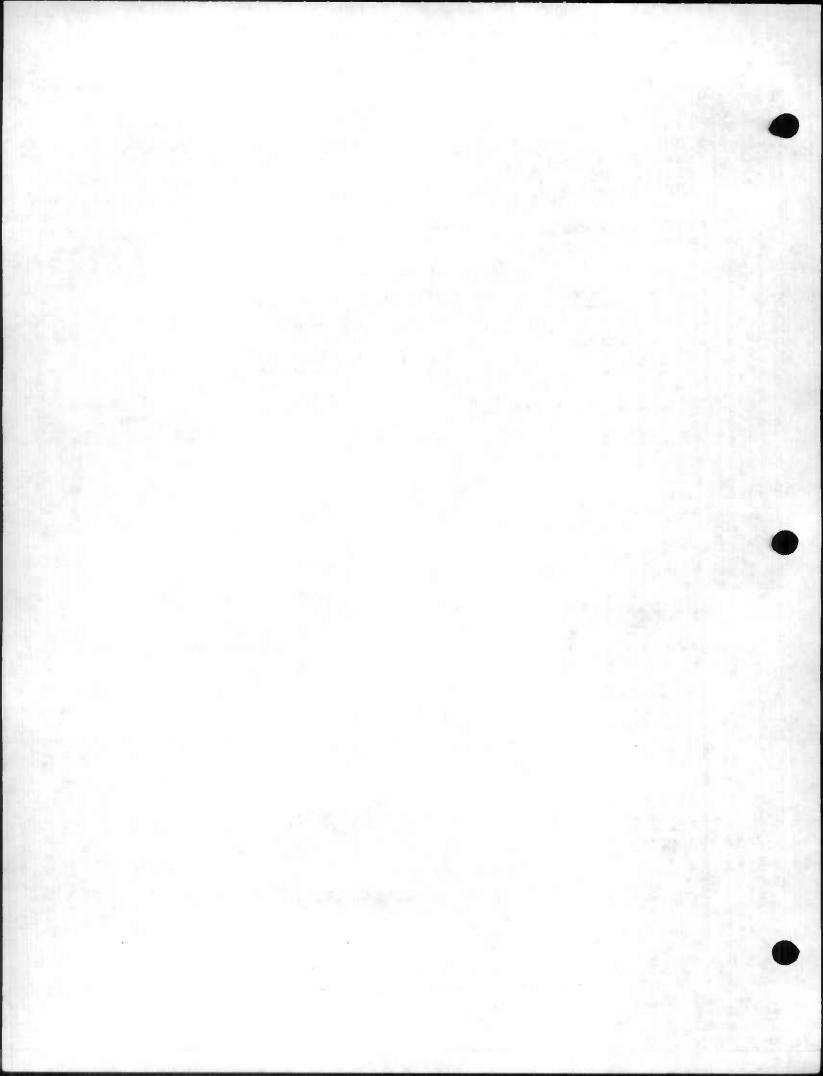
· State Registrar 31. Dete filed (Month, Dey, Year) MAR 01 2000 32. Registrar's Signeture

Deale

after death.

Diractor: After this certificata I
d in by the funeral director, pag or Attending Physician:

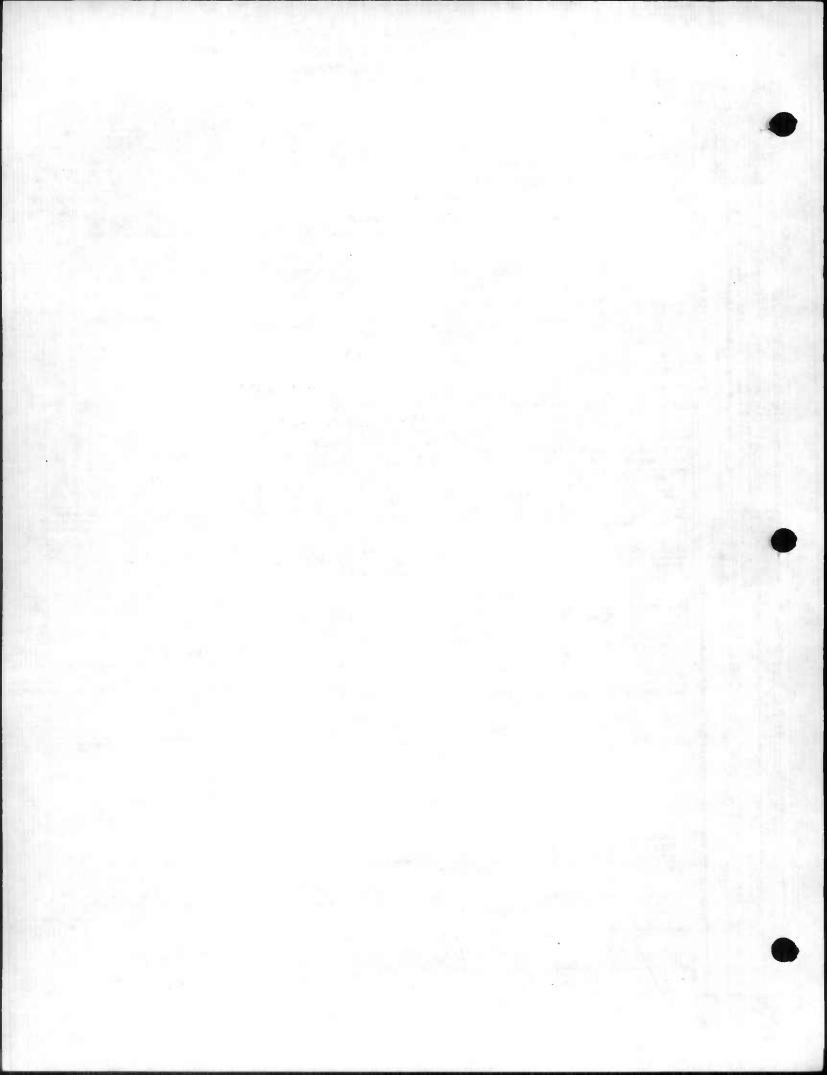
within 24 hours a



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

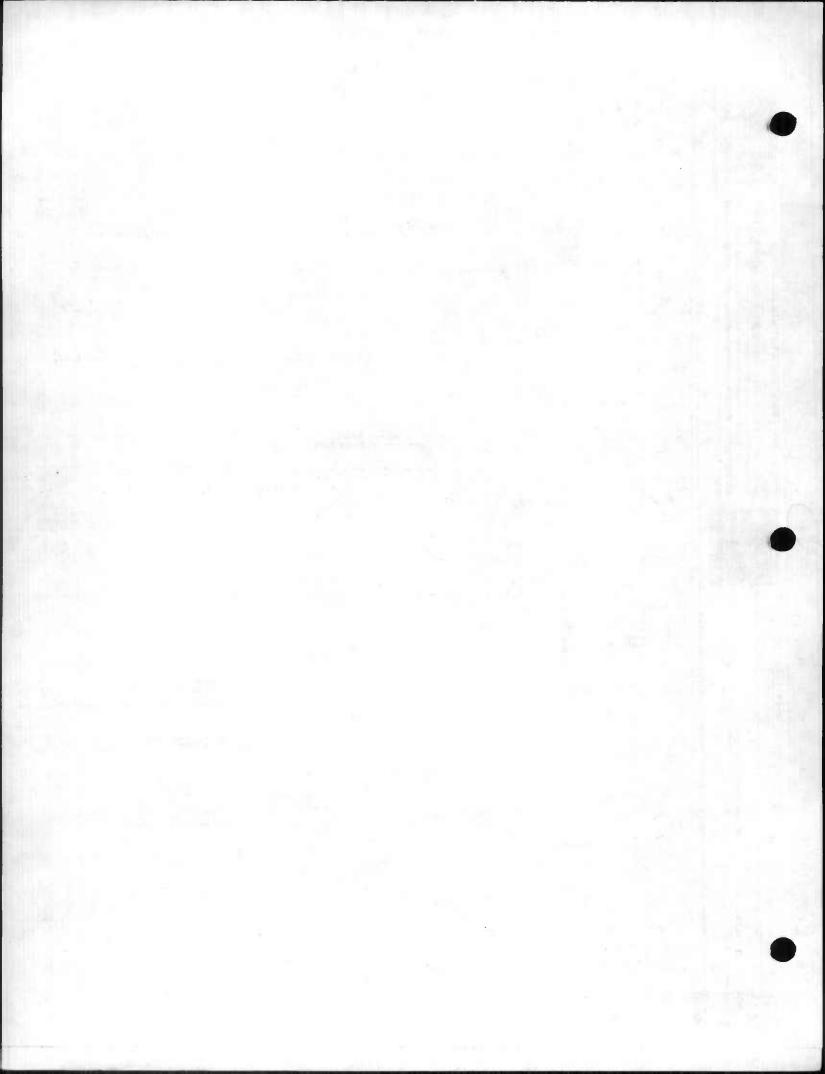
State of Maryland / Department of Health and Mental Hygiene 0 0 6 5 2 7

			Certificate o	f Death	Re	g. No.					
5 11-1-	1. Decedent's Nama (First, Middle, Last)				2. Data of Death Month	Day Yes	3. Tima ol Death				
Physiciar /Medica	Floo Martha Po.	ehrle			February	27, 2000	8:10am				
Examine	4a Fecility Name (If not institution, giva stre			4b. City, Town, or	Location of Death	4c. County of De	eath				
	Randolph Hills Nurs	ing Home		Wheaton		Montgon	nery				
Funeral Director	5. Social Security Number 6. Sex 1 N	7. Age (In yrs. last	t birthday) If Under 1 Ye Yrs. Months Day		8. Date of Birth (Month, Day, August 2	9. E 0, 1907	Birthplace (Stata or Foraign Country) Germany				
P .	Usual Residence of Decedent	140-00-7					Lead to the first time.				
oth with the Merylen 23e or 28e-f show	10e. State 10b. County		Town or Location				10d. Inside City Limits 1 ☐ Yas 2 ②No				
vith the Me.	Maryland Montgomer	y Silv	er Spring								
5 6	10e. Street and Number		10f. Zip Cod		10	g. Citizen of What	Country?				
£ 53			209	-		Germany					
	3 ☑ Widowed 4 □ Divorced	Was Decedent Ever in U,S. Armed Forces? 1 □ Yes 2 ☒ No If Yas, Giva Year or Dates;	13. Was Decedent of If Yas, specify C	of Hispanic Origin? (Suban, Mexican, Puert Jo Specify:	pecify Yas or No- o Rican, atc.)	14. Race - Al Black, W Specify: \[
72 hours	15. Decedent's Educat		16a. Decedent's Usual Oc (Giva kind of work do.	cupation	ting 1	6b. Kind of Busina	ss/Industry				
within 2 men.	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12) 1 2	College (1-4or 5+)	lifa. DO NOT use ret	ired)	King						
	12		Production	Assistant		Medical	Supply				
Maryland 2 dd 2 should be filed the end Mental Hygi the end Mental Hygi the end Mental Hygi the end was a filed the end other the end of the end t				18. Mothar's Nar	na (First, Middle, M	ddle, Maiden Surnama)					
aryla should to marked umaric	Ernst Kofahl	collection for		Bertha	Scheffler						
Mar d 2 sho th end 7 le ma treum	19a. Informant's Name/Relationship (Type,	Print)	19b. Mailing Address (Stra	eet and Number or Ru	ıral Route Number,	City or Town, State	a, Zip Code)				
~ 6 9 7 6	Christa Fookes / Da		12800 Lacy I e of Disposition (Name of		ver Sprin	g, Maryla	and 20904				
Baltimore, North Peges 1 end 3 pertment of Heelth Important: If Heelth Inthe Internation of Other trans.	20a. Method of Disposition	Oc. Location - City	or Town, Stata								
The Page	1 ☐ Burial 2 ② Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	Brentwood	d, Maryland								
Baltimori permit. Peges 1 Department of H important: If Ne eny Injury or of pncs.	21. Signature of Paneral Service Licensee			dress of Facility Hir							
D SEES	8/107	11/1-0	11800 Ne	w Hampshir	e Avenue	000/					
	23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one	ions that caused the death.	Do not entar tha mode of	pring, Man	cyland 20	0904 st.	Approximate				
/Medical Examiner	Immediate Causa (Final disease or condition resulting in death) a	,	s a consequence of):	ary was	eulard	islase	gears				
tificate be og physicia es the bur	Cause (Disease or injury that initiated events resulting in death) Last		s a consequence of):								
deeth cent of for use	d										
de d	Part II. Other significant conditions contrit	uting to death but not resulting	ng in the underlying causa	given in Part I.	23b. Dld tol	pacco use contrib	ute to the cause of death				
s, F.C. BOX set that the deeth cer gened by the estendir be deteched for use					1 □ Ye	• 20No 3□	Probably 4 Unknow				
been should					24a. Was an		b. Wara autopsy findings available prior to completion of cause of death?				
The level at the best pege 2					1□ Ya	s 2 No	1 ☐ Yas 2 ☐ No				
certificate frector, peg				26 Place of De	ath (Check only one	0					
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	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, atc. (Specify)	a, farm, atreet, factory, offi	ce	28f. Location (Str. City or Town,	eet and Number or State)	Rural Routa Number,				
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3	30. Name and address of person who comp	leted cause of death (Item 23			VSINGTO	SNIMD.	20895				
State Registrar	31 Data filed (Month, Day, Year)	32. Registrar's Signatura	4 1			1					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 0 5 2 8

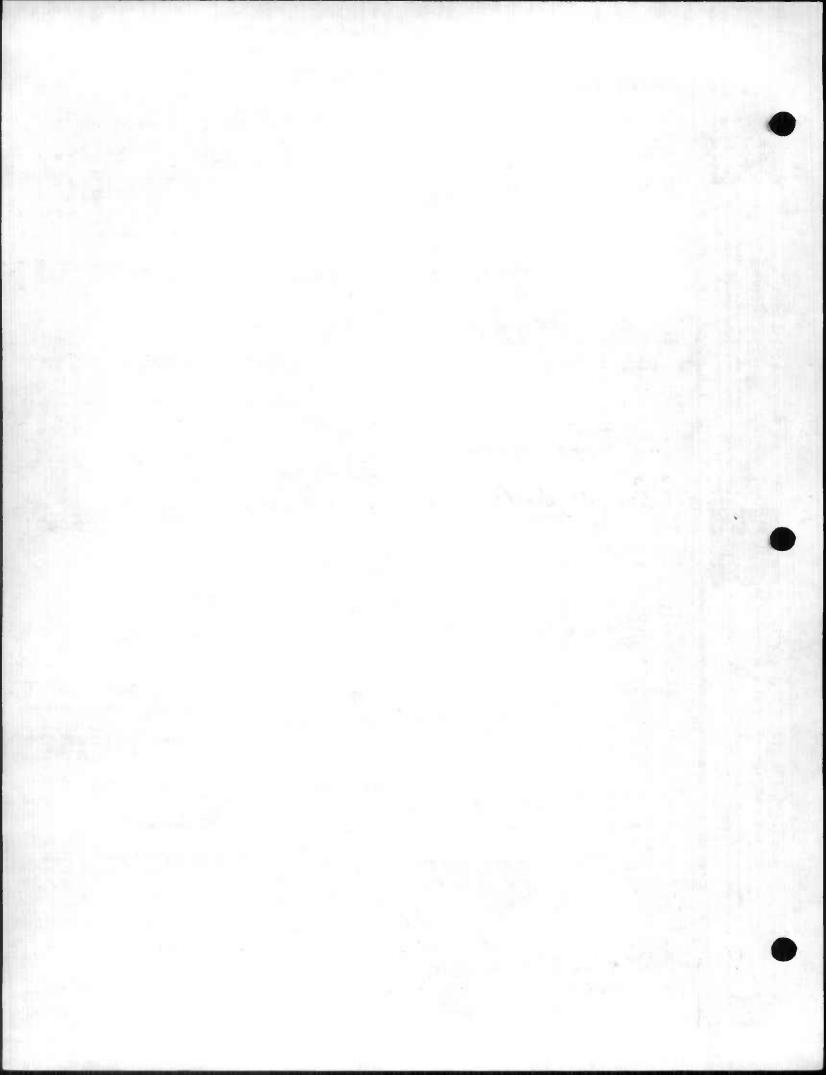
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	68760	bur bur	Cause (Diseese or Injury	d c								I		
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4	0	The lew require sate has been single 2 should				-				perfo	med?	CC	mplelion	of cause
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10										10	res 2 No	1.	Yes	2□ No
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2.7		G.	30. Neme and address of person	on who completed cause	of death (Ite	m 23a) (1	Type, Print)							
			Catherine Mc	Coy, M.D.	8600 0)1d G	Georget	own	Road, Bet	hesda. N	(arvland	1 20	814	
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State of Maryland / Department of Health and Mental Hygiene (1) (1) (1) (2) (2)

				,	Ce	rtifica	te of	Death		Reg. No.		0 0 200	
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	or 28s-f s be notified	DC 10e. Street and Number		Was	Hilligto		ip Coda			10g. Citizen of 1	What Count	try?	
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alti	A finds	21. Signature of Funeral Sarvice L						ess of Fecility Collins				57	
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	Physician /Medical Examiner	Immediata Causa (Final disaesa or condition resulting in deeth)	a. Acute		ardial or as a conse			on				Sudden	
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		30. Nama and addrass of person w	ho completed causa	of death (Ite	m 23a) (Type	, Print)							
		Peter Schissler		0 Gree	nway C	ente	r Dr	#430	Greenb	elt , MI	207	770	
	State Registrar	31. Data liled (Month, Day, Year)	32. Rec	plstrar's Sign	atura 4		on K						



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Harry Vin	cent Ro					В.			
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Doreen Barron /	Sister	109	Karv	a K	ourt	Marti	nsburg	Wes	st Va.
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1 2 2	11. Marital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade) Elemantary/Secondery (0-12) 17. Father's Name (First, Middle, Last) Harry Vin 19a. Informant's Name/Reletionship (Ty) Doreen Barron 20a. Method of Disposition 1 Burial 2 Cramation 3 R 4 Donation 5 Other (Specify) 21. Signeture of Funeral Service License 23a. Part1. Enter the disease, or complication of the shock, or heart failure. List only on the shock, or heart failure. List only on the shock of the shock	11. Marital Status 1	11. Marital Status 1	11. Marital Status 10. Mar	11. Marital Status	11. Marital Status 1 12. Was Decodent Evar in U.S. 2. Agend Process 1. 12. 13. Was Decodent of Hispanic Origin? 13. Was D	11. Merital Status 12. Mes Decedent Evair in U.S 13. Wes Decedent of Happanic Origin? (Specify Yes or N Apped Forces* 1966 13. Wes Decedent of Happanic Origin? (Specify Yes or N Apped Forces* 1966 1976 1	11. Marital Status 12. West Decodent Ever in U.S. Agged Forcest? 1966 1967 1968 1968 1968 1969 1978 1968 1969 1978 1968 1969 1978 1969 1978 1969 1978 1969 1978 1969 1978 1969 1978 1969 1978 1969 1978 1	11. Marital Status 12. Was Decedent Ear in U.S. Agmed Protes? 19.66 19

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Theodore King M.D.

111 Penn Street, Baltimore, Maryland 21201

31. Data filed (Month, Day, Year) 2000 State Registrar

32. Aegistrar's Signatura

/15/19. 1 75-07-17 CULI

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Data of Death 3. Tima of Death

Physician /Medical Examiner **Funeral** Director

Director

by

Completed

Be

Manyland 28a-f show must be notified 6 Items 23a the Medical Examiner filed within 72 hours efter 'natural', or I Hygiene. marked other

Baltimore, Maryland 21215-0020 Peges 1 end 2 should be nent of Health end Mental traumatic or other traur Department of Important: If any Injury or once. **Physician** Examiner Examiner The law requires that the death certificate be executed sician and buriel-trans Box 68760. Physician/Medical the 98 P.O. Records. by 2 page 2 should Completed Division of Vital Attending Physician: Be Certification: To this : After t death. il Director: A 6 To the Hospital
within 24 hours e
To the Funeral I
completely filled Medicai 3

1. Decedent's Name (First, Middle, Last) Month JOHN FLOYD ROBERTSON MARCH 3 2000 2:00 PM 4a. Facility Nama (If not institution, giva straet and number) 4b. City. Town, or Location of Death 4c. County of Death CUMBERLAND NURSING HOME CUMBERLAND
If Under 1 Year If Under 24 Hrs. 8. Da ALLEGANY 5. Social Sacurity Number 6. Sax 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthptace (State or Foreign Country) 1 M 2□ F Days Hours 81 Yrs. 214-07-6220 APRIL 6 1918 MARYLAND 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND ALLEGANY 1 ☐ Yes 2 ☐ No OLDTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? P.O. BOX# 70 WAGNER ROAD 21555 U.S.A. 12. Was Decedent Ever In U.S. Armed Forces? 1XXves 2 No If Yes, Giva Yaar or Dates: 1944–1945 11. Marital Status Was Dacedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Raca - Amartcan Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorcad Specify: WHITE 15. Decadent's Education (Specify only highest grade completed) 16a. Decadent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Ktnd of Bustness/Industry Elamantary/Sacondary (0-12) Collaga (1-4or 5+) 10 BALTIMORE & OHIO RAILROAD RAILROAD 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maidan Surname) WILLIAM FRANKLIN ROBERTSON POLLY JANE SHROUT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) WILLIAM F. ROBERTSON JR BROTHER 516 RHODE ISLAND AVE. HAGERSTOWN MARYLAND 21740 20a. Method of Disposition 20b. Placa of Disposition (Nama of cametery, crematory or other placa) 20c. Location - City or Town, State 1 ☐ Burial ZCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4 Donation CUMBERLAND CREMATORY MARCH 4 2000 CUMBERLAND MARYLAND Signature of Funeral Service Lies 22. Name and Address of Facility
MERRITT-ADAMS FUNERAL HOME P.A. einel 404 DECATUR STREET CUMBERLAND MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death bmont Immediate Cause (Final SMALL CELL CA LUNG disease or condition resulting in daath) Due to (or as a consequenca of): Sequentially list conditions, if any, leading to Immediate cause. Entar Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last Due to (or as a consequenca of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was casa rafarred to madicat axaminer? 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day Yaar) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ∏Yes 2 ∏No 2 Accident 6 Could not be 3 Suicide 28e. Placa of Injury - At homa, farm, streat, factory, office building, etc. (Spacify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homleida Lectifying Physician: To the best of my knowtadge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the best of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner statad. 29a, Cartifier (Check only one)

na State Registrar

DR QAMAR U. ZAMAN 31. Date filed (Month, Day, Year)

MAR 0 6 2000

29b. Signature and titla of certifier

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

625 KENT AVE CUMBERLAND MARYLAND 21502 ooks

29c. Licansa numbar

D23371

29d. Date signed (Month, Day, Year) March 3, 2000 THE RESERVE

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00008532

Usual Residence of Decedent 10e. Stata 10b. County MARYLAND ALLEGANY 10e. Street and Number 11618 KEMP DRIVE	Medical C 1 2 F 64	yrs. last birthday) Yrs. City, Town or Loc	10f. Zip Code 2.1			Day 18, 2 h 4c. County Alle rth ay, Year) 1935	gany 9. Birthp Court MARY		
ROBERT MAXWELL RAFT 4a Facility Nama (If not institution, give street Memorial Hospital & 5. Social Security Number 217 30 2004 Usual Residence of Decedent 10a. Stata 10b. County MARYLAND ALLEGANY 10a. Street and Number	Medical (7. Age (In 64 10c F) Was Decedent Ever Armed Forces? 120 Yes 2 No If Yas, Giva	yrs. last birthday) Yrs. City, Town or Loc	cation 10f. Zip Code 2 1	Cumberlar If Under 24 Hrs. Hours Min.	Februa: ocation of Deal ad a. Data of Bi (Month, D	ry 18, 2 h 4c. County Alle rth ay, Year) 1935	000 of Death gany 9. Birthp Coun MARY	olaca (Stata or Foreign Itry) LAND Od. Inside City Limits	
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MARYLAND ALLEGANY 10e. Street and Number 11618 KEMP DRIVE	Was Decedent Ever Armed Forces? 1X☐Yes 2☐No If Yas, Giva	ROSTBURG	10f. Zip Code 2.1	532		10a Citizon at 1			
11618 KEMP DRIVE	Armed Forces? 1X Yes 2 No If Yas, Giva	in U,S. 13. V	21	532			Og. Citizen of What Country?		
12. Parital Status	Armed Forces? 1X Yes 2 No If Yas, Giva	in U,S. 13. V				U.:	S.		
11 Never Married 21 Married		1	f Yes, specify Cut	Hispanic Origin? (Spoan, Mexican, Puerto Specify:	ecify Yes or No Rican, atc.)	Bla	e - Amaric ck, Whita, WHIT	atc.	
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Elementary/Secondary (0-12)	College (1-4or 5+)			ed)		m T D	r.		
12 17. Father's Name (First, Middle, Last)		MILL	ROOM	18. Mother's Nam	n (Cinnt Middle	TIR:			
CHARLES P. RAFFERTY					. GLOTI		rei.)		
				L PIKE, G					
20a. Mathod ol Disposition Burial 2 Cremation 3 Rem Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	oval from Stata	b. Place of Dispos cematery, crem RANTSVIL	natory or other pla		Data 22/00	20c. Location GRANTSV			
21. Signature of Funeral Service Licensee		SO		ass of Facility IERAL HOME IST., FRO		MD 215	32		
•	Metastat		oma				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Iniarval Batween Onsat and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contrit		o (or as a consequence o (or as a consequence o					1		
	outing to death but not	resulting in tha ur	nderlying causa g	iven in Part I.				the cause of death?	
E XD .					10	Yes 2 No	3 Pro	bably 4 Unknow	
requires should been should be shoul					24a. Was	s an autopsy omed?	av co	ara autopsy lindings allable prior to mpletion of cause death?	
The law Page 2 2 Page 2 2 Page					10	Yes 2 No		Yes 2 No	
25. Was casa refarred to medical examiner?				26. Place of Deal					
	pital: 1 Inpatient	2 ER/Outpatien	t 3 DOA O	hor		idence 8 Ott	ar (Specif	(v)	
27. Manner of Death 27. Manner of Death 2 Accident 3 Suickle 4 Pleorieide 4 Pleorieide	28a. Data of Injury (Month, Day Yea	28b. Tima of Injury	W	ry at ork? Yes 2 No	28d. Describe	how injury occur	red		
27. Manner of Death 1 Death of the control of the	28a. Place of Injury - / building, etc. (Sp	At home, larm, atm ecity)	eet, lactory, office		28f. Location City or To	(Street and Number, Stata)	ber or Rura	l Route Number,	
29a. Certifier 1 Certifying Physici	Certifying Physician: To the best of my knowledge, death occurred at the time, data as Medical Examiner: On the basis of examination and/or investigation, in my opinion, detail and manner stated.					cause(s) and m , data and place,	annar as a and due to	lated. tha cause(s)	
	King			License number 29d. Data signed			d (Month,	Day, Year)	
10 Name and officer of a constant and	/ -	(ham 00-) (T	D 36	6766		February	21	, 2000	
30. Nama and address of person who comp				e. MD 21	502				
State Registrar FEB 2 2 2000	32. Registrar's S	110-110	Loca Na	/					

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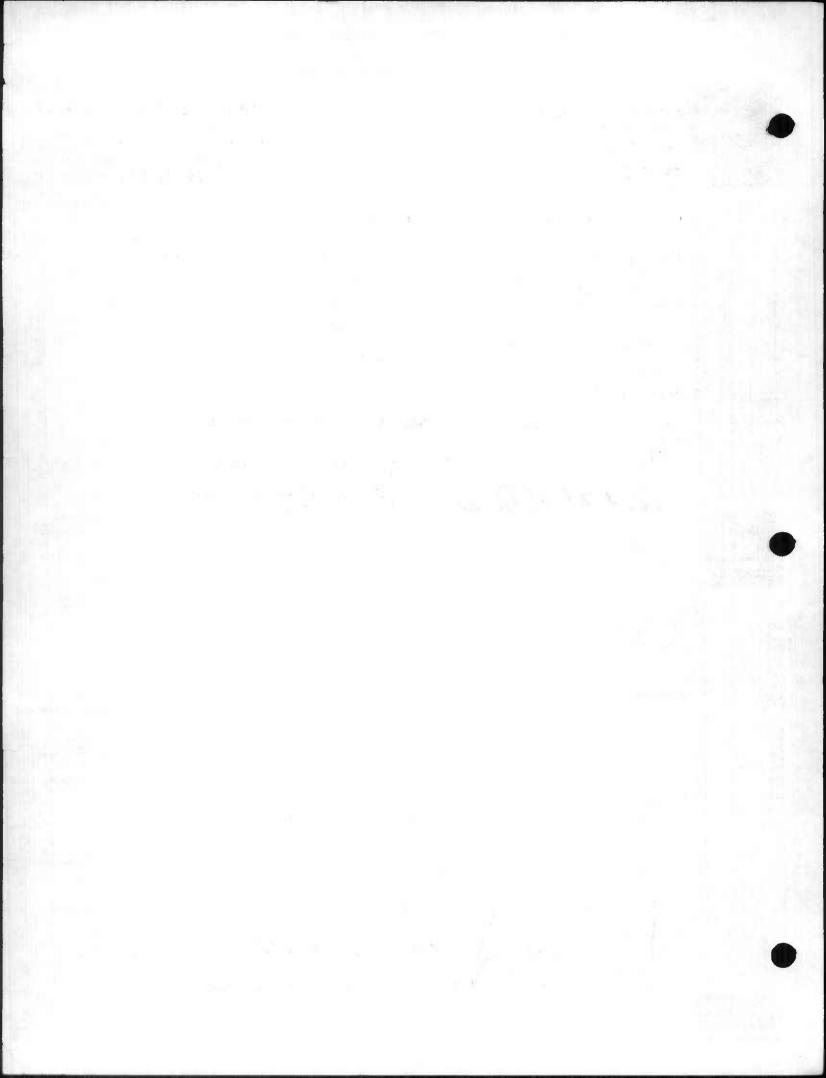
Robert Rafferty

and the same

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State of Maryland / Department of Health and Mental Hygiene (

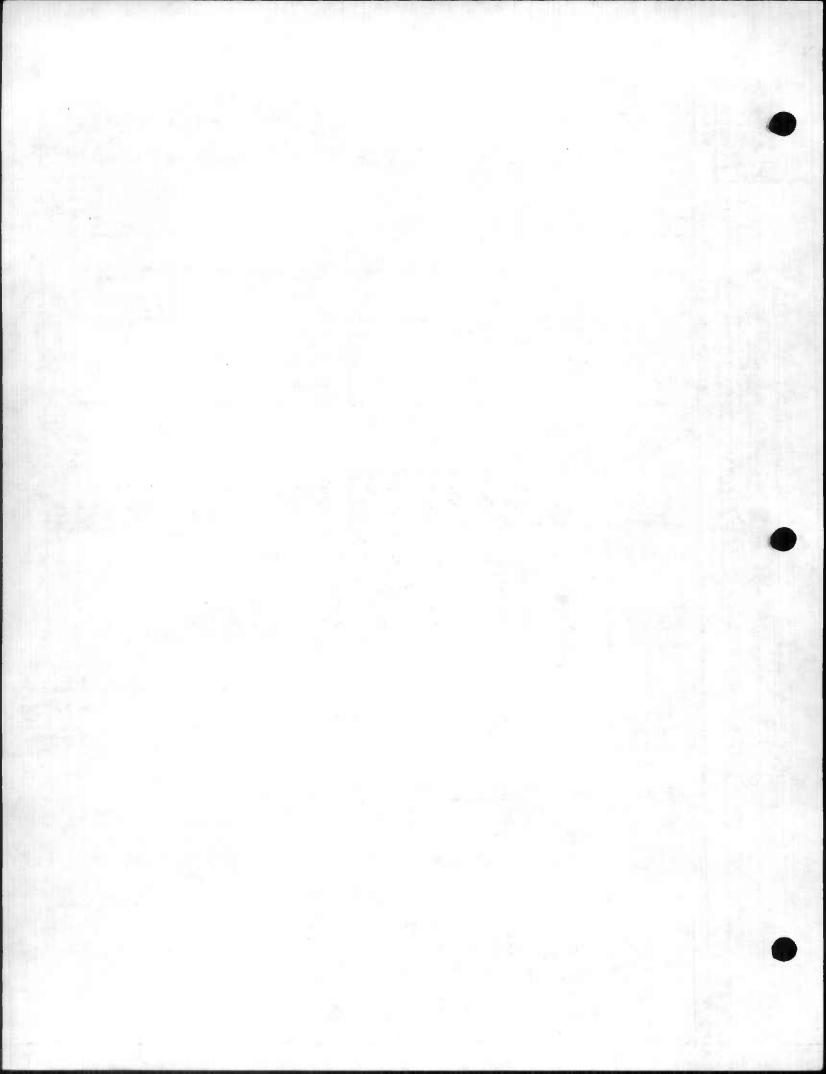
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/Medica Examine		4a. Facility Nama (If			ber)				4b. City, Town, or				0.00 At1
Examine		102 Dogwood							Stevensv	i 11e	Queen		1 8
Funeral		5. Social Security Nu		Sex 7	. Age (In yrs.	last birthdey)	If Under	1 Year	if Under 24 Hrs	8. Data of B	-		oleca (Stata or Foreign
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S Ver	0	James B.							Unknow	Co. Co. Co.	a, maroan soman	raj	
To Be Comp	2	19a. Informant's Nar				19b. Maliir	no Addrass	(Street	and Number or R		ber. City or Town.	Stata. Zin	Code)
rtrau		Edwin J.							r Court		MD 2073		
othe .		20a. Method of Dispo				Placa of Dispo	sition (Nam	a of	ice)	Data	20c. Location -	City or To	own, Stata
7 0		4 Donation	Cremation 3 Cothar (Spec	Ramovai from S	St	evensv				ebruary	22, 2000	Ste	vensville M
important: if item 27 is any injury or other trai- once.		21. Signetup of Fun	121	1/01	ben	F	ellow:	s. 1	Helfenber	in & New	mam Fune	ral 1	Home
sician edical miner		23a. Part1. Entar the shock, or heart Immediate Cause (F disaasa or condition resulting in death)	inai	a.	hy	or as a consec	rd	a or ayı	J Ju	1	tron		Approximate Interval Batween Onset and Death
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foru	2	Date III Other all alline							301-2-3	1		1	
o detached for use		Part II. Other signific	ant conditions	contributing to dea	ith but not ras	ulting in tha u	ndarlying ca	ausa gi	van in Part I.		1 tobacco usa col		bably 42 Unknown
page 2 should be det	ואופופת									24a. Wa	s an autopsy formed?	av co	ara autopsy findings ailable prior to mpletion of cause death?
pag	5									1□	Yas 2 No	10	☐Yes 2☐ No
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led in by the tunera		3 Suicide 4 Hemicide	6 Could not determine	d 28a. Place c	of Injury - At he g, etc. (Specif	ome, ferm, str	aat, factory,	, office			(Street and Numb own, Stata)	per or Rura	al Routa Number,
pletely fill	29a. Certifiar (Cleck only of e) 1							me, dete end plec opinion, death occ	e, and dua to the urred at tha time	a causa(s) and ma , data and place,	ennar as si and dua to	tated. o tha cause(s)	
Comp									se number		29d. Date signe	d (Month,	Day, Year)
	1	A	1	Sun	-	W	2	0	20575	4	2-1	8-0	00
		30. Nama and addres	ss of person who	complated causa	draath (Itan	23e) (Type,	Print)		/				
	1	Dr. Ralph	Libby 2	04 Media			Gras	sonv	ville, MD	21638			1 (SS-1-14
State Registrar		31. Data filed (Month	Bay 2 2 2!	32. P	glarar's Signa	itura 4	100						



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State of Maryland / Department of Health and Mental Hygiene

						Cei	rtificate d	of Death		Reg. No.	UU	085,	34
Physic			A (First, Middle, Las						2. Dete of D Month	eath Day	Year	3. Time o	f Death
/Med	lical _		len Raune		mber)			4b. City, Town	Feb, or Location of Dea	26	2000 inty of Death	1:30	AM
Exam	iner								aston		Talb		
Funera Director		5. Social Security N 220-05-09 Usual Rasidence of	00		The P 7. Age (In yrs. 8	last birthday)	If Under 1 Ye	ear If Under 24		ay, Year)	9. Birth	place (Stete	
Maryland of show fled at		IOe. Stete	10b. County		10c. Cit	ly, Town or Lo	ocation					10d. Inside C	City Limits
e Maryti ta-f sho	S W	aaryland	Talbot		Ea	ston						1 🗆 Yes	2 No
eth with the Mar 23s or 28s-f si ust be notified	ā	10e. Street end Nur 12 Park L	ane, Hyde	Park			10f. Zip Coo			10g. Citizen USA	of What Cou	intry?	
0020 burs after des net, or items Examiner m	by Fur	1 Marital Status 1 Never Merri 3 Widowed	ed 23 Married 4 Divorced	12. Was Dece Armed Fo 1 Yes If Yes, Giv Yeer or D	2ENO		Wes Decedent If Yes, specify (1 ☐ Yes ———————————————————————————————————		? (Specify Yes or N Puerto Rican, etc.)		Pace - Amer Black, White ecity: Wh		
21215-0020 d within 72 hours at piene, r than "natural", or the Medical Exam	Completed	(Speci	15. Decedent's Edity only highest grad		I-4or 5+)	(Give		cupation one during most of tired)		16b. Kind o	f Business/fr	ndustry	
	S	17. Father's Neme	(First, Middle, Last)			Dead.			Neme (First, Middle				
aryland should be file and Mental Hy rearked oth umatic event	To Be	Harry Kat	ten					Hele	n Nuentha	1			
fary 2 sho and 3			me/Reletionship (7						or Rural Route Num			ip Code)	
e, N	-			uner /			ark Lan		Park East			Town State	
altimore, mit. Pages 1 a partment of He portant: if Hem y Injury or othe	1		Cramation 3 1 5 Other (Specify		State Che	sapeak	e Crema	place) tion Feb	ruary 28,	Cheste	on-City or Ter, Ma	ryland	į.
Ball Department of the part of		> The	nerel Sarvice Licens May be disease, or composition failure. List only of	Ha	funder aused the deet each line.	in Fi	ellows, 06 Sham	rock Rd.	ein & New chester,	MD 216		Home Approxima Interval Be Onset and	etween
Physician /Medical Examiner		Immediate Cause (diseese or conditio resulting in death)	Final n	. <u>a</u>	S Pue to (9	atur	Propuence of):	ceumn	ie			48 1	hrs
bed is	nine			b. 1	ran		n CV	4			- 1		
Box 68760, seth certificate be executed attending physician and for use as the burial-transit	ledic	Sequentially list con if any, leeding to im- ceuse. Enter Unde Cause (Disease or thet initieted events resulting in death) I		c. Ce	retra	or es a consec	terio	scleve	i Rh	emiple	gri	5 yr	3
Geeth deeth of for	Sic a	Part II. Other signif	cant conditions co	ntributing to de	eath but not res	ulting in the u	nderlying cause	given in Pert I.	23b. Did	i lobacco use	contribute	to the cause	of death?
Is, P.O. Box es that the deeth cer igned by the attendin be detached for use	by Physician/N	ASH	D WIL	111			my De above	Α	10	Yes 200	lo 3 Pr	obably 4] Unknown
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the deeth cerwithin 24 hours after deeth. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, pege 2 should be detached for use	Completed	Conje	estre 1	fearl.	Failui	e 2° (abory			s en eutopsy formed?	8	Were sutopsy evailable prior completion of of death?	to
n: The ficate or, peg		25. Was case refer	and to modical							Yes 300N	0 1	Ves 2□	□No
F VIII	To Be	examiner?	+	Hospitel: 1 🗆 I	Inpatient 2	ER/Outpatier	nt 3□ DOA	Other	Deeth (Check only ing Home 5 ☐ Res		Other (Spec	cify)	
On Of ding Phy th. After this funeral		27. Manner of Dean 1 Veturel 2 Accident	5 Pending investigation	28a. Dete		28b. Time o Injury	28c.	njury at Work? 1 Yes 2 No	28d. Describe	how injury oc			
Division American State of the Holy State of the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	256. Piece	of Injury - At h	ome, ferm, str	reet, fectory, off	ice	28f. Location City or To	(Street and No own, Stete)	umber or Ru	ral Route Nur	mber,
he Hospi in 24 hour he Funer pletely fill		29a. Certifier (Check only one)	1 Certifying Phy 2 Medicat Exam	ner: On the ba	best of my kno asis of examine nar stated.	wiedge, deet tion and/or in	h occurred et the vestigation, in r	e time, date end p ny opinion, deeth	place, end due to the occurred at the time	e ceuse(s) and , date end pla	d menner as ce, and due	steted. to the cause((s)
To the Total	2	29b. Signature and	May	He	Voluel	1	29c. Lic	bense number	15	29d. Dete si	Z 6	Day, Year)	
	3	O. Neme end eddre	ess of person who cases 610 Du	ompleted ceus tchman'	e of deeth (Item s Lane	East	Print) on, Mar	yland 216	501				PH III
St	ate	31. Dete filed (Mont	h, Day, Year)		egistrees Signa	ature	4	1					



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			of Maryland /								_	08535
					tificat					Reg. No.		00000
1. Decedent's Neme	e (First, Middl	le, Last)							2. Deta of Dea		Vana	3. Time of Death
BERTHA	ANNA	A REMBO	OLD						Febru	ary 21.	200	0 1630
4a Facility Name (II	f not institution	n, give street and nu	ımber)			4	lb. City, To	own, or L	ocation of Death			
Fallstor	Gener	cal Hospit	al				Fa	llst	on	Н	arfo	ord
5. Social Security N 216-30-8		6. Sex 1 ☐ M 2 🖾 F	7. Age (In yrs. last b	virthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Data of Birt (Month, Da) Jan. 9	y, Year)	9. Birt Co	hplaca (Stata or Foreign ountry) Ohio
Usual Residence of									Julia 9	1320		CALLO
10a. Stata	10b. County		10c. City, To	wn or Lo	cation							10d. Inside City Limits
Maryland	Har	ford		Jopp	a							1 ☐ Yas 2 💢 No
10e. Street and Nun	nber				10f. Zip	Code				10g. Citizen of	What Co	ountry?
2515 Mou	ıntain	Road				2:	1085			U	SA	
11. Marital Status 1 Nevar Marri 3 Widowed	1000	ried 1 ☐ Yes	21 No	1	Was Deced f Yas, spec 1 ☐ Yas	cify Cuba	ispanic Or an, Mexica Specify:	n, Puerto	ecify Yes or No- Rican, atc.)	14. Rac Bla Specif	ck, White	rican Indian, a, atc.

16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired)

Anna

McComas Funeral Home, P.A.

Factory Worker

Holly Hill Memorial Park

22. Nama and Addrass of Facility

20b. Place of Disposition (Nama of cematary, cremetory or other place)

"natural", or items 23s or Baltimore, Maryland 21215-0020 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens. Importants if hem 27 is mented other than 'n any Injury or other trainmented other than 'n

Physician

/Medical

Examiner

Funeral

Director

28a-f

must be

Paul

21. Signature

Directo

þ

Completed

99

Elementery/Secondary (0-12) 8

20a. Mathod of Disposition

17. Father's Nama (First, Middle, Last)

Peter

19a. Informant's Name/Reletionship (Type, Print)

4 ☐ Donation 5 ☐ Othar (Specify)

15. Decedent's Education (Specify only highest grada completed)

Betty J. Johnstone - Daughter

Burial 2 Cremation 3 Removal from Stata

Puneral Service Licenses

College (1-4or 5+)

Szoltyk

Physician /Medical Examiner

Ber.

Rembold

Examine 8

the ettending physician and shed for use as the burisl-transit Division of Vital Records, P.O. Box 68760 been signed by the ette should be detached for Pes page 2 this certificate To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

Physician/Medical p Completed Certification: To

Immediata Causa (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23a. Part1. Erflar tha disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one vause on each line. se consequence di) Dua to (or as a consequence of)

Dua to (or as a consequence of):

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 25. Was casa referred to medicat axaminar? 26. Place of Death (Check only ona)

Hospital:

5 Pending investigation

6 ☐ Could not be determined

EINHALD

28a. Data of Injury (Month, Day Year)

2003

Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1, Impatient 2 ER/Outpatient 3 DOA 28b. Time of 28c. fnjury at Work?

1 ☐ Yas 2 ☐ No

Zic. License number

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 112 Certifying Physician: To the best of my knowledge, death occurred at tha tima, data and place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

24a. Was an autopsy performed?

1 Yas 2 No

Mitola

18. Mother's Neme (First, Middle, Maiden Sumema)

Marie

2/25/00

19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 3308 Pritchett Iane, Fallston, MD 21047
Loc of Disposition (Nama of Data 20c. Location - City or Town, Stata

16b. Kind of Businass/Industry

Shoe Manufacturing

Baltimore, Maryland

21009

23b. Dfd tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown

29d. Data signed (Month, Day, Year)

105

Approximate fntarvat Between Onset and Death

24b. Were autopsy findings available prior to

completion of cause of death?

1 ☐ Yas 2 ☐ No

, Lock

(Check only one) 29b. Signatura and titla of certifier

30. Name and progress of pe

1 Yes 2 No

27. Manner of Death

1 DNetural

2 Accident

3 Suicide

29a. Certifier

JOSE

4 Homicide

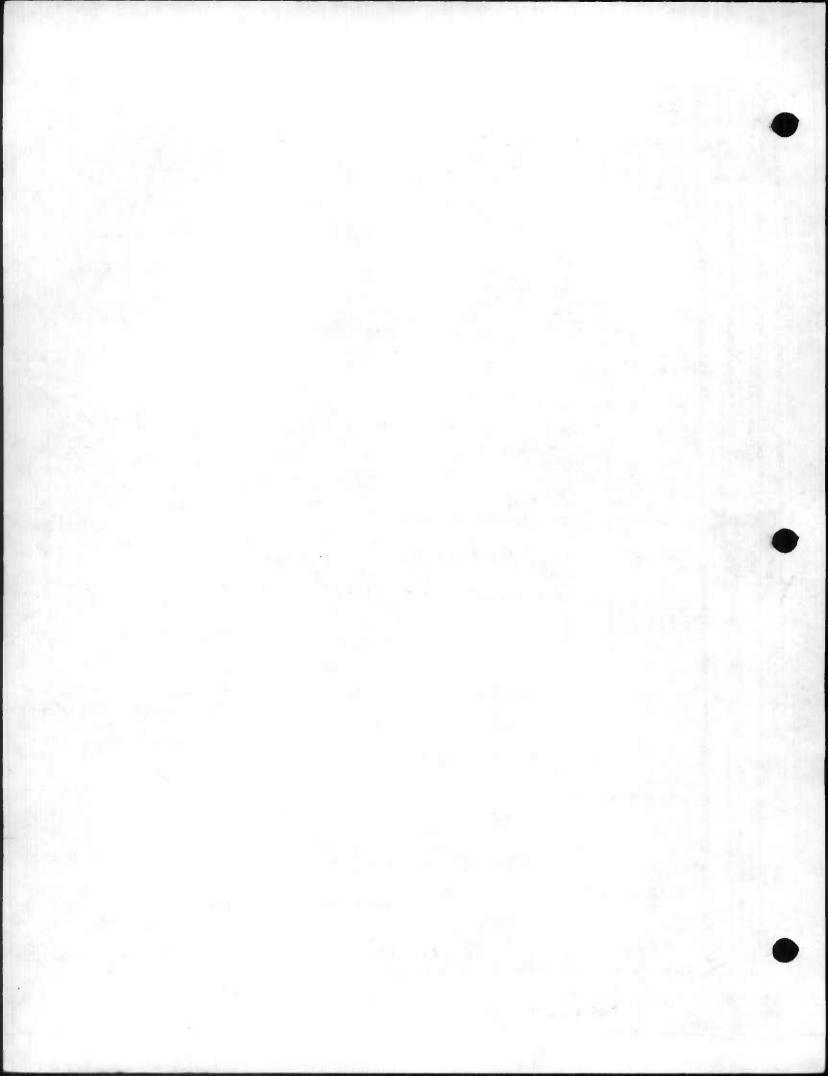
rson who completed cause of death (Item 23a) (Type, Print)

Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

LOCK 32. Registrar's Signatura

State Registrar

edical

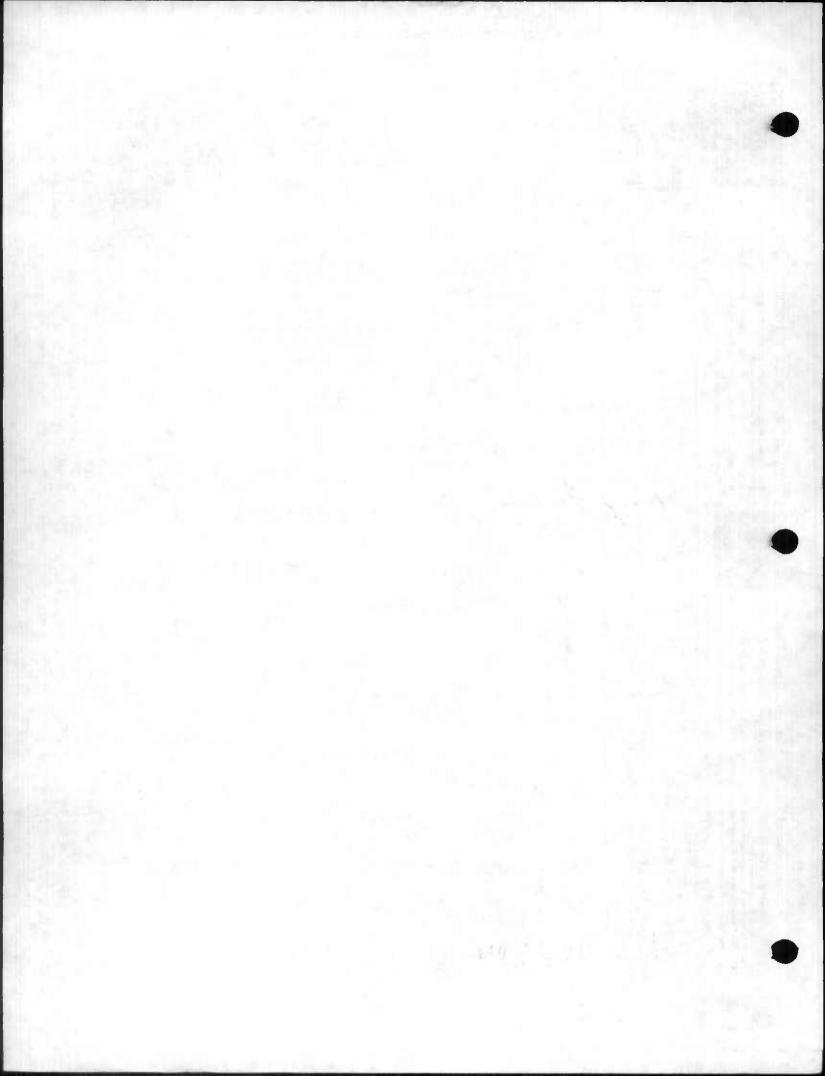


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State of Maryland / Department of Health and Mental Hygiene

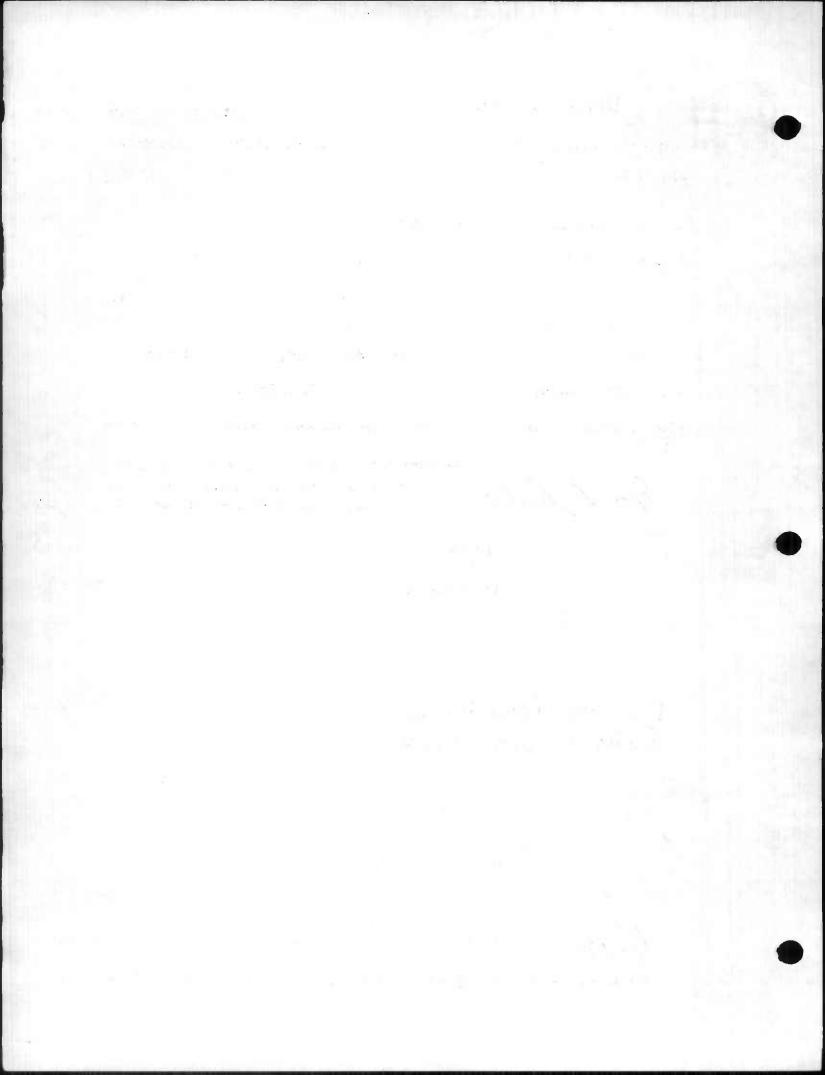
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				Certific	cate of	Death		3	Reg. No.		000	0.0	
	Decedent's Name (First, Middle, Last) 2. Date of Death								ath Day	Year	3. Time	of Death	
Physician (Madian)	Walter Francis Sacko							ebrua:		2000	2:20	PM	
/Medical Examiner	4a Facility Name (If not Institution, give					4b. City, To	wn, or Locati				14,60	FN	
LAdillillei	11430 Strand Drive #416						Rockville Montgomery						
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hi												
tor		Months D						8. Dete of Birth (Month, Day, Year) November 10, 1925 9. Birthplece (Stete or Foreign Country) Pennsylvania					
tal	Usual Residence of Decedent										ISYLV	ania	
	10a. State 10b. County 10c. City, Town or Location									10d. Inside City Limits			
	Maryland Montgon	nerv		Rockvi	110			1 □ Yes				s 2 No	
Directo	10e. Street and Number 10f. Zip Code								10g. Citizen of What Country?				
5 A G		. шлас		101									
1						352	1000		United States				
Funeral	11. Marital Status				Was Decedent of Hispanic Origin? (Specify f Yes, specify Cuban, Mexican, Puerto Rica			can, etc.)		Race - American Indian, Bleck, White, etc.			
	1 Never Married 2 Married	1 XYes 2 No If Yes, Give T.T.T. T.T.		1 Yes 2 No Specify:					Specif	Specify:			
d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates: WW II								White			
ete	15. Decedent's Ed (Specify only highest grades)	ucation de completed)	cation 16a		 Decedent's Usuai Occupation (Give kind of work done during most of work life. DO NOT use retired) 				16b. Kind of B	16b. Kind of Business/Industry			
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NO	OT use retir	red)							
Š		2		Agen	t				Insurance				
Be	17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (Fi	irst, Middle,	lle, Maiden Surname)				
ToE	John Sacko						Len An	en Anuszewski					
7 is mar traumat	19a, Informant's Name/Relationship (Type, Print) 19b, Mailing				iress (Stree	et and Numbe	er, City or Town,	City or Town, State, Zip Code)					
	John Sacko/Son		52	1 Line	oln A	venue.	Tako	ma Pa	ark, MD 20912				
	20a. Method of Disposition		20b. Place o	f Disposition	(Name of		-	Date	20c. Location				
	1 ☐ Burial 2 ☐ Cremetion 3 ☐			ny, cremetory		Ter		cuary					
	4 □ Donation 5 □ Other (Specify		Montgo	mery Cre			-0.	2000	Bethesda, Maryland				
	21. Signeture of Funerel Service Licen			Robe	rt Add	ress of Facilit	rev Fi	inera	Home/I	Rethe	sda-C	hevy	
	21. Signeture of Funerel Service Livensee 22. Name end Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 23a. Parl 1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Inc. Approximate interval Between Onset and Death											nc.	
	23a. Part 1. Enter the disease, or comp	olications that coused	the deeth. Do	not enter the	mode of d	ying, such as	cerdiac or re	spiratory a	rrest,		Approxin	ate	
	snock, or neart tailure. List only one cause on each line.								Onset and De				
	Immediate Cause (Final Coronary Artery Disease							20			20 170	are	
r	disease or condition resulting in death)							20 years					
6			Due to (or as a	consequence	9 Ot):					1			
Examiner		b											
Xar	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying	Due to (or as a consequence ot):											
	Cause (Disease or Injury	C	c										
edicai	thet initiated events resulting in death) Last		Due to (or es e consequence of):										
2													
ed by the attending physician and deteched for use as the burial-transit Physician/Medical Examir	Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.							23b. Did	tobacco use co	ontribute to	o the caus	s of death?	
hy								1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unkno					
sate hes been signed , page 2 should be de Completed by P								24a. Was an autopsy 24b. Were autopsy tindings				y tindings	
								performed? available p			mpletion o		
mp											of death?		
								10	Yes 2⊠No	1[□Yes 2	□ No	
Be etor	25. Was case referred to medicel examiner?	11 - 5 -					e of Death (C	heck only	one)				
10	1 ☑ Yes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho.							dence 8 Dot	her (Specil	(y)		
	27. Manner of Death	28a. Date of Injur (Month, Day	Year) 28b.	Time of	28c. In	jury at	28d	. Describe	how injury occu	rred		3 77	
atic	1 Naturel 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day Year) Injury Work?					No	A LANGE OF THE PARTY OF THE PAR					
Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f.		Street and Num	ber or Ruri	al Route N	umber,	
ert	4 Homicide							City or Town, State)					
	29a. Certifier 1 X Certifying Phy	veicien: To the best o	my knowled-	e deeth cor-	trad at the	time data co	nd place and	due to the	cause(s) and m	anner es e	hated		
edical		ysician: To the best of inner: On the basis of	examination ar									e(s)	
To the Funeral Dir completely filled in Medical Cert		and manner sta	o d.		200 Hine	nee number			29d Date sign	ad (Month	Day Vac	1	
-	29c. License number D29229								230. Date signe	d. Date signed (Month, Dey, Year)			
						29229			February 22, 2000				
	30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)										1, 17		
	Martin S. Kanovsk	y, M.D. 5	530 Wis	sconsir	Ave	nue #7	30. Ch	evv C	hase, M	arvla	and 2	0815	
tate	31. Date filed (Month, Day, Year)		r's Signature	6	/	0.0	50, 51.	, ,	11			0015	
State	EED 0 8 200	10 /20-00	1	~ 1	no K	47							



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		1. Decedant's Nema (First, Middle, La	(st) - C			2. Data of Da Month	Reg. No. leth Day	Yaer	3. Tima ol Deal		
Physician /Medica	ai -	Darrell 4e. Facility Nama (If not institution, give	W. Sal	iev			4b. City, Town, or I	Februa	ry 26,	2000 unty of Death	9:00 pm
Examine		Holy Cross Hospit	al				Silver Sp	oring	Mont	gomery	
Funeral Director		5. Social Sacurity Number 6. S 230-48-3062 Usual Rasidanca of Dacedant	Sax 7. Aga 1 ☐XM 2 ☐ F	(In yrs. last birt	thday) If Under Months		If Under 24 Hrs. Hours Min.	8. Deta of Bir (Month, Da June 1	th ly, Year) .7, 193	9. Birth Cou 37 Vir	plece (State or For ntry) ginia
show		10a. Stata 10b. County		10c. City, Towr	n or Location					T	10d. Insida City Lin
noilited at		Maryland Montgome 10e. Street and Number	ry	Kensin	gton 10f. Zip	Coda			10g. Citizan	of What Cou	1 ☐ Yas 2(☐ ntry?
		3223 Edgewood Roa	d		208				USA		
0 5	by Fur	11. Marital Status 1 □ Navar Married 3 □ Widowad 4 □ Divorced	12. Was Dacedant E Armed Forces? 1 ☐ Yas 2 🗓 No If Yas, Giva Yaar or Datas:		13. Was Daced If Yes, spec		lispanic Orlgin? (S en, Maxican, Puart Specify:	pecify Yes or No o Rican, atc.)		Raca - Ameri Black, Whita, ecify: Wh:	atc.
Is marked other than "natural", raumailc event, the Medical Eve	Be Completed	15. Dacedant's E (Specify only highast gra	ada completed)	16a.	16a. Dacedant's Usual Occup (Giva kind of work dona lifa. DO NOT usa ratired		pation during most of working		16b. Kind o	f Business/In	dustry
t, the	EOS	Elamantary/Sacondary (0-12)	Collage (1-4or 5-	Collage (1-4or 5+)			Manager		-		
7 Is marked other traumatic event,	1	17. Fathar's Nama (First, Middla, Last, Walter Scott Saly					18. Mothar's Nan Ruth Fre	Magruder's a (First, Middle, Maidan Sumama) eman al Routa Number, City or Town, Stata, Zip Code) ensington, MD 20895			
ls mar aumat	-	19a. Informant's Nama/Ralationship (19b.	Malling Addrass	s (Street		ural Routa Number, City or Town, Stata, Zip Code)			o Code)
Department of Health Important: If itsm 27 any injury or other tr once.	20a. Mathod of Disposition 20b. Placa of Disposition (Natical Buriat) 2 Cremation 3 Ramoval from State							Data 20c. Location - City or Town, Stata			_
ortant:	1	4 Donation 5 Other (Specify) Norbeck Memorial Park 21. Signature Funeral Service Licenses 22. Name and Address of Facility									
Impor any in		Pru S.	Kerlo		Francis	s J.	Collins	Funeral	L Home	Sprin	o. MD 20
/sician		23a. Part . Enter the diseesa, or com shock, or heart failure. List only	plications that caused tone cause on each line	the daath. Do n	not antar tha mod	de ol dyir	ng, such es cardiad	or raspiratory a	rrest,	J P L L	1
ledicai aminer		Immediate Causa (Final disaasa or condition rasulting in daath)	a. 08/	1513							12 hour
o attending physician and additional and additional and additional and additional additi				Dun to (05 00 0 0	onessunes of						
isi grafi	line		b. Ga	oua to (or as a constant	consaquanca of):						4 week
an and rial-transit		Sequantially list conditions, if any, laading to Immadiate causa. Entar Undarfying	b. Ga	Oua to (or as a confidence of the organization) Oua to (or as a confidence of the organization)	consaquanca of):						4 week
as the bur	Vedical	Sequantially list conditions, if any, laading to Immadiate causa. Entar Undarlying Causa (Disaase or Injury that Initiated awants rasulting In daath) Last	c	Dua to (or as a c	consaquanca of): consaquenca of): onsaquanca of):						4 week
or use as the bu	Vedical	that initiated avants rasulting in death) Last	c	Dua to (or as a c	onsaquenca of):			201-214			4 week
or use as the bu	riiysician/medical	rasulting in death) Last	cD d	Oua to (or as a c	onsaquenca of): onsaquanca of): tha undarlying c		an in Part I.			contribute t	4 WCC (C
gned by the attending physicie be detached for use as the but by Dhysician Microsoft	Dy Physician/medical	that initiated avants rasulting in death) Last	cD d	Oua to (or as a c	onsaquenca of): onsaquanca of): tha undarlying c		an in Part I.	1 □		contribute to	o the cause of de
has been signed by the attending physicis ge 2 should be detached for use as the burnieted by Dhysicis	completed by Filysicianymedical	Part II. Other eignificant conditions of End Stage Lischemic	cD d	Oua to (or as a c	onsaquenca of): onsaquanca of): tha undarlying c			1 □	Yes 2□ N an autopsy prmed? Yes 2 N	contribute to a property of the contribute to a property of th	o the cause of de
is certificate has been signed by the attending physicia director, page 2 should be detached for use as the but Re Completed by Drivel classification and proposed to the completed by Drivel classification and complete completed by Drivel classification and complete complet	be completed by Filysiciarumedical	rasulting in death) Last	cD d	Dua to (or as a contract to the transition of the contract of	consaquenca of): onsaquanca of): I the underlying c	eausa giv	28. Placa of Das	24a. Was perfo	Yes 2□ N an autopsy rmed? Yes 2₩ N ona)	contribute to 3 Pro	o the cause of de bebly 40 Unk Vara autopsy findicallable prior to morplation of cause death? Yas 20 No
Inter this certificate has been signed by the attending physicis funeral director, page 2 should be detached for use as the button. To Re Completed by Division Macalization	to be completed by Filysicianymedical	Part II. Other eignificant conditions of End Stage LSChemic 25. Was casa rafarred to medical axaminar? 1 Yes 2 No 27. Mannar of Death 1 Natural 5 Panding Invastigation	c	Dua to (or as a contract to the contract to th	consaquenca of): onsaquenca of): onsaquenca of): other undarlying consequence where the consequence of the c	Pausa giv	28. Placa of Dae aer: 4 Nursing H	1 □	Yes 2 N an autopsy rmed? Yes 2 N ona) dance 8	contribute to a Procession of the Contribute to	o the cause of de bably 40 Unk
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his certificate has been signed by the attending physicial director, page 2 should be detached for use as the but of Re-Completed by Dhyselvian Macellan	redical certification. To be completed by Filysician/Medical	Part II. Other eignificant conditions of End Stage LSChemic 25. Was casa rafarred to medical axaminar? 1 Yes 2 No 27. Mannar of Death 1 Natural 5 Panding Invastigation 3 Suicida 4 Homicida 29a. Certifiar (Check only 2 Medical Exam	d. d. Cardon Hospital: 1 Inpatian 28a. Data of Injury (Month, Day) a 28a. Placa of Injury building, atc. yslclan: To tha best of ninar: On tha basis of a and mannar state	Dua to (or as a control of the contr	tonsaquence of): onsaquence of): onsaquence of): onsaquence of): the underlying c	DA Oth Rec. Injur Wor 1 y, office at tha tir , In my o	28. Placa of Dae aar: 4 Nursing H y at k? Yas 2 No na, data and placa plnion, daath occu	24a. Was performed to the Check only of the Check only only of the Check only of the Check only of the Check only of the	Yes 2 N N Nona) dance 8 how Injury oc Streat and Nimm, Stata) causa(s) and data and pla 29d. Data si	contribute to the contribute t	o the cause of de peably 40 Unku / Ara autopsy findin rallable prior to mmplation of cause daath? Yas 20 No / Ara Anna Anna Anna Anna Anna Anna Anna
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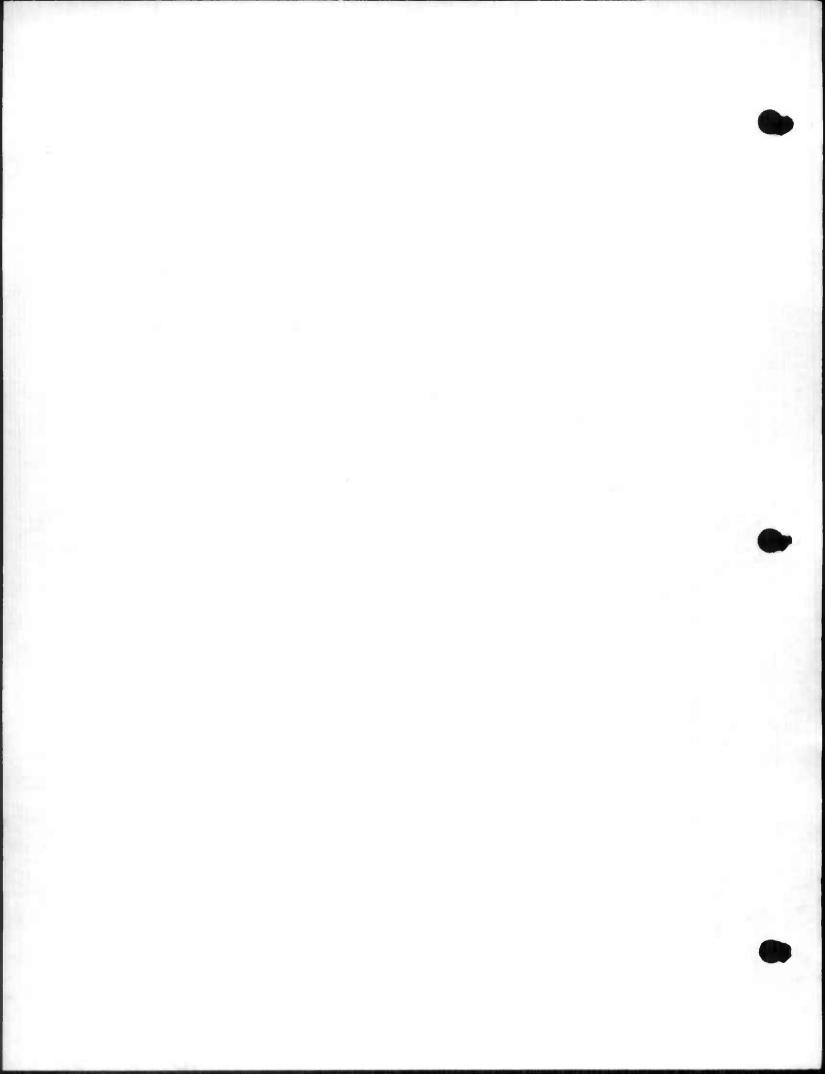


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MPORTANT: if Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

	STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL	HYGIENE
GISTRAR	CERTIFICATE OF DEATH	REG. NO.

	FOR 1 - STATE REGISTRAR	STATE OF MARY		TMENT OF H		MENTAL HYGIEN		
	1. DECEDENT'S NAME (First, Middle, Last)	0.1.1				2. DATE OF DEATH		3. TIME OF DEATH
	Robert B.	Scheel,	Sr. E (In yrs. last birthday)	IF UNDER 1 YEAR		February		
	578-05-6481	1 😡 M 2 🗆 F	82 YRS.	MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sep. 10,	1917 New	HPLACE (State or Foreign ry) York
DIRECTOR	90. FACILITY NAME (If not institution, give str Fairland Adventist		ome		Spring	EATH	ery	
EC	RESIDENCE OF DECEDENT 10a. STATE 10b. COUNTY		10c. CIT	Y, TOWN OR LOCAT	ION		10d. INSIDE CITY	
	Maryland Montg	gomery	Si	lver Spr			LIMITS?	
ERA	2101 Fairland Road	d _		101	20904		USA	WHAT COUNTRY?
BY FUNERAL	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER FORCES? 1 X YE IF YES, GIVE WAR OF WW II	S 2 NO	If yes, sp		NIC ORIGIN? (Specify Years, Puerto Rican, etc.)	a or No — 14. RACI Blac Spec	E — American Indian, k, White, atc.
COMPLETED	15. DECEDENT'S EDUC (Specify only highest grade of Elementary/Secondary (0-12)	ATION	18a. DECEDENT'S (Give kind of life. Do NOT us	USUAL OCCUPATION Mork done during more retired.)	ON st of working	16b. KIND OF BU	SINESS/INDUSTRY	
AP.	12	Conega (I-4 or 5 +)	C	lerk		Feder	al Gover	nment
BE CO	17. FATHER'S NAME (First, Middle, Lest) Christian G. Sche	eel				ME (First, Middle, Maiden obtainable		
10 8	19a. INFORMANT'S NAME (Type/Print) Patricia Blake / I	Daughter				Route Number, City or Town	,	113
	20a. METHOD OF DISPOSITION 1 Surfal 2 Cremation 3 Remo 4 Donation 8 Other (Specify)	wal from State	ob. PLACE AND DATE	of Disposition (Na ther place)	med Park O	0ATE 20c. LO	CATION — City or To	wn, State Mary 1 and
	21. SIGNATURE OF FUNERAL SERVICE LICE	ENSEE	I al Klawii	22. NAME A	O ADDRESS OF FA	curvHines-R	inaldi Fu	ineral Home
	Cours &	Di My		Silve	r Spring	pshire Ave , Maryland	20904	
	23. PART I. Enter the diseases, or conshock, or heart failure. LIMMEDIATE CAUSE (Final disease or condition resulting in death)	let only one cause or	ped the deeth. Do so each line. NOVASCUE S A CONSEQUENCE O	LAR A			iratory arreat,	Approximate interval Between Onset and Death
EHILIFICATION	Sequentially list conditions, if any, leading to immediate cause. Entar UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		S A CONSEQUENCE OF					
MEDICAL C	PART II. Other algnificent conditions	contributing to death	but not resulting	in the underlying	cause given in	Part I. 24s. WAS AN PERFOR	RMED?	. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
	DID TOBACCO USE CONTR	BUTE TO CAUSE	OF DEATH YE	S I NO F	UNCERTAI	 N []		1 TES 2 12-110
HYSICIAN:	25. WAS CASE REFERRED TO MEDICAL EXAMINER?		28. PLACE OF DEA	TH (Check only one)	, OTTOLKIAN			
2	1 TYES 2 NO	HOSPITAL: 1 Inpetient 2 ER/O	utpatient 3 DOA	OTHER:	5 Residence	8 Other (Specify)		
BY PH	27. MANNER OF DEATH 1 Netural 5 Pending 2 Accident Investigation	28a. DATE OF INJUR (Month, Day, Year		URY WO	URY AT RK? 'ES 2 NO	26d. DESCRIBE HOW I	NJURY OCCURED	
5 I	3 Suicide 6 Could not be detarmined	28e. PLACE OF INJU building, etc. (S	RY — At home, farm, specify)	street, factory, offic		281. LOCATION (Street a City or Town, State)		Route Number,
COMPLETE	29e. CERTIFIER (Check only one) 1 CERTIFYINO PHYSIC 2 MEDICAL EXAMINER							e) and manner as stated.
O BE C	296. SIGNATURE AND TITLE OF CERTIFURA	_111)			29c. LICENSE NUI	MBER 97	≥ 2/2	(Month, Day, Year) 24/2000
-	30. NAME AND ADDRESS OF PERSON WHO 2015 A. CASA			Print) ZRY LANE	- LAUI	rec mo	20707	
	S1. DATE FILED (Month, Day, Year) FEB 2 8 2000	12. RECOSTRAR'S SIG		bouls				
			1					



State of Maryland / Department of Health and Mental Hygien

Certificate of Death

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lo.	00	U	0	0	Ú	-

		ent's Name (First, M	fiddle, Las)							2. Date of De Month	ath Day	Year	3. Time of Death	
Physicia /Medic	I Oh	n Otto S	Schre	iber									y 21, 2000 6:50		
Examine	4 - 17 1914	y Name (If not instit	ution, give	street and no	umber)				4b. City, To	own, or Lo	ocation of Deat	4c. Count	y of Death		
F	Ho	Ly Cross	Hospi	tal					Silve	er Sp	pring	Montg	omery	•	
Funeral	5. Social :	Security Number	6. Se	X M 2 F	7. Age (I	In yrs. last birth	Month	s Davs		24 Hrs. Min.	(Month, Da	th ly, Year)	Cou	place (State or Foreign	
Director		60-2376		M ZUF		87 Y	rs.				Sept.18	3, 1912	Wash	D.C.	
g .	Usual Res	sidence of Deceden			110	Oc. City, Town	or Location	ocation					1	10d. Inside City Limits	
e Maryi Se-f sho diffed at	No	ne No				Washin		D.C.						1 X Yes 2 No	
		W Street	.N.W	- 51				Zip Code 20007	7				U.S.A.		
020 un after deal af, or flerre	11. Marita 1 N 3 125 W		Married	12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 42-46			pecify Cul	of Hispanic Origin? (Specify Yes or No- cuban, Mexican, Puerto Rican, etc.) No Specify:			Ble	14. Race - American Indian, Black, White, etc. Specify: White			
5-0 72 ho	pet		dent's Edi				sual Occu	pation	et of work	laure	t6b. Kind of E	Business/In	dustry		
2121 within within then	Elemen	(Specify only history/Secondary (0-1	1		(1-4or 5+)		We. DO NOT	use retin	ed)	SI OF WORK	any	Food &	Drug	Admin.	
and the fined of t	17. Fathe	17. Father's Name (First, Middle, Last) John Herman Adolph Schreiber										Maiden Suma arklewi			
Maryland 21215-0020 Q 2 should be filled within 72 hours at It and Mental Hygisen. ** natural", or T is marked other than "natural", or traumatic event, the Medical Exam	19a. Info	mant's Name/Relat	ionship (T	ype, Print)		19b.	19b. Mailing Address (Street and Number or Rural Route 5147 Woodhaven Ct. Flint,						, State, Zij	o Code)	
- 5 9 10 2		od of Disposition	erper	/ BLOCK	20b. Place of Disposition (Name of								20c, Location - City or Town, State		
altimore mit. Pages 1: partment of He portant: if hem y Injury or othe	108	1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cemetery, crematory or other pi Metropolitan Cre								- 0	eb. 25,			Virginia	
Balt permit. Depart Importu	21. Signa	ture of Funeral Sen	vice Licens	0	1	11			Ave.	. D		neral H			
Physician	23a. Part sho	Mer the disease or heart tailure.	e, or comp List only o	lications that ne cause on	caused the each line.	e death. Do no	ot enter the m	ode of dy	ring, such as	cardiac	or respiratory a	rrest,	1	Approximate Interval Between Onset and Death	
/Medical Examiner	disease o	Immediate Cause (Final disease or condition resulting in death) Pneumonia									1				
	5					e to (or as a co							i		
58760, icate be executed physician and it the burial-transit	Sequentia if any, les cause. E	ally list conditions, ding to immediate nter Underlying	ſ	0	Du	ve Hear									
	that initial	isease or Injury led events in death) Last	1	c. Quadriparesis Due to (or as a consequence of):											
Box (78			O									1		
15, P.O. Iss that the deligned by the a	Pert II. Ot	nary Arte			death but n	not resulting in	the underlying	cause g	iven in Part	1.	1 1 20 11 20			to the cause of death?	
Records,	Pert II. On Coro Leuk Chro											an autopsy omed?	a	Vere autopsy tindings vailable prior to ompletion of cause	
The law	Chro	nic Renal	[Fai]	lure	46						10	Yes 211 No	O	l death? ☐ Yes 2☐ No	
it it		ase referred to me	dical			7 4			26. Plac	e of Deat	th (Check only	one)			
G 5 7 -	-	es 2 No		Hospitat:	Inpatient	2 ER/Out	patient 3	DOA	ther: 4 N	ursing Ho	ome 5 Resi	dence 6 □Ot	her (Speci	ity)	
Afre fune			nding estigation	28a. Date (Moi	of Injury nth, Day Yo	(ear) 28b. Ti	me of ury M	28c. Inje We 1 [ury at ork? Yes 2	No	28d. Describe	how injury occu	rred		
Division I or Attending after death. Director: After d in by the fune	2 3□ 8	uicide 6 Co	ould not be termined	28e. Plac build	e of Injury ding, etc. (S	- At home, fan Specify)	n, street, fact	ory, office			28f. Location (City or To	Street and Num wn, State)	ber or Rui	ral Route Number,	
	29a. Cert	ck only 2 Med	ifying Phy ical Exami	ner: On the t	e best of m basis of ex	amination and	death occurre or investigation	ed at the ton, in my	time, date a opinion, de	nd place, ath occur	and due to the red at the time,	cause(s) and m	annar as:	stated. lo tha cause(s)	
To the compi		ature and title of cer	rtifier	1.	2. 1	1 00 0	173	9c. Licer	nse number	270	0 /	29d. Date sign	ed (Month	, Day, Year)	

10

30. Name and address of person who compared ited cause of death (Item 23a) (Type, Print) Aimee Seidman, M.D.
31. Date filed (Month, Day, Year) 2309 Shorefield Road, Wheaton, Maryland 20902

State Registrar

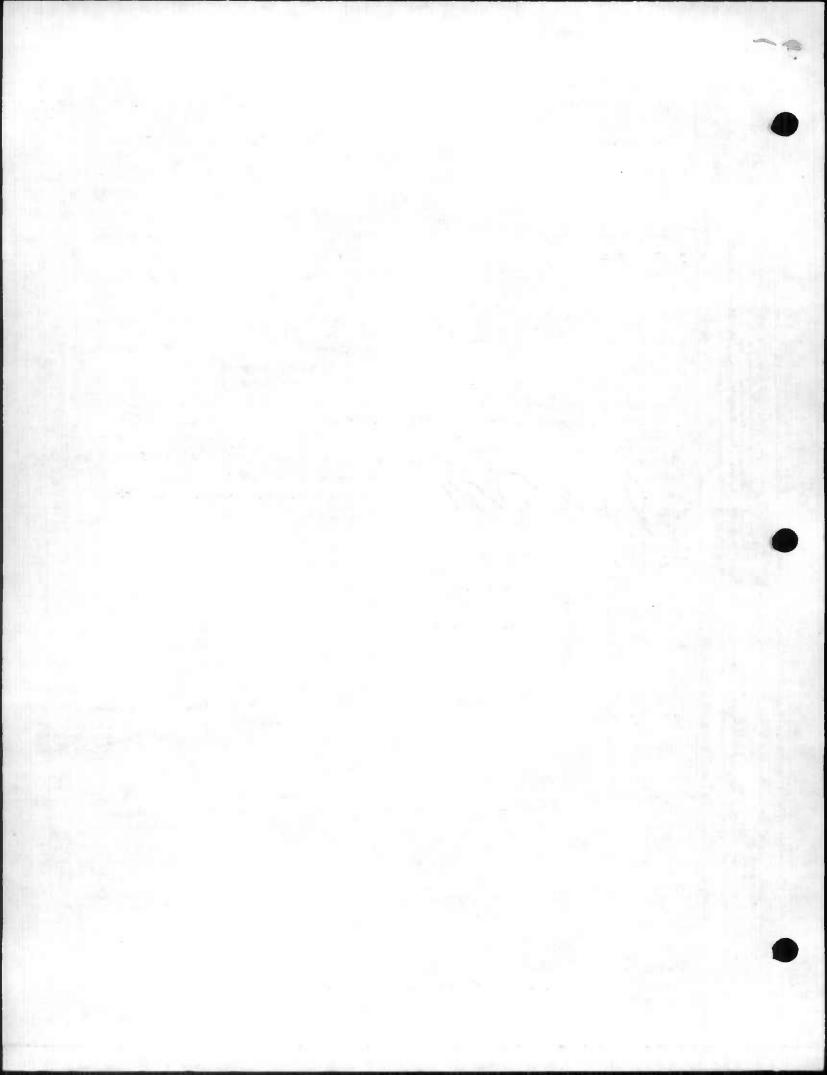
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mee

32. Registrar's Signature

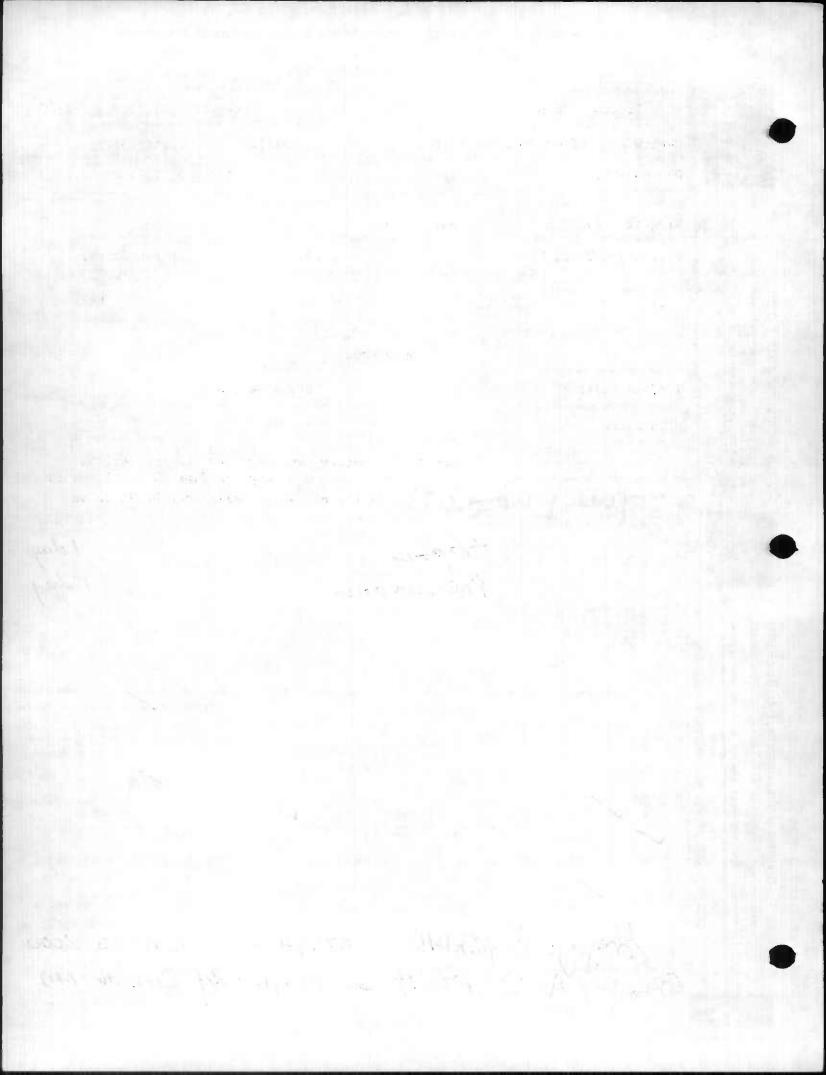
D37801

February 24, 2000



State of Maryland / Department of Health and Mental Hygiene 00 0 5 4 0

ician					Cer	uncau	e or r	Death		Reg. No.	200	
ician	1. Decedent's Name	e (First, Middle, La	ist)	5.39					2. Date of De		Vess	3. Tima of Death
	Lee Lede	erman Sha	piro						Februar	Dey 26,	Year 2000	2:00
dical niner	4e Facility Neme (I	f not institution, giv	re street and number)			- 4	b. City, Town, or		-	nty of Deeth	
	Hebrew Ho	ome of Gr	eater Was	hingto	n		F	Rockvill			gomery	7
	5. Social Security N		Sex 7. A 1 □ M 2 ဩ F	ge (In yrs. la:	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hrs Hours Min	. (Month, D	rth ay, Year)	Cour	
	073-03-92 Usual Residence of			84					October	5, 19	15 New	York
	10a. State	10b. County	DOMESTIC TO	10c. City,	Town or Loc	cation		H-1 m s			1	0d. Inside City Lim
ō	Virginia	Fairfax		Spri	ngfie	1d						1 □ Yes XX
5	10e. Street and Nur	mber				10f. Zip	Code	wit is		10g. Citizen of What Count		
alD	7711 Wago	on Trail	Lane				221	153	United St			es
Funeral Director	11. Marital Status 1 ☐ Never Marri	ied 2 Married	12. Was Decedent Armed Forces 1 \(\text{Yes} \) 2 \(\text{X} \)	?					(Specify Yes or No- lerto Rican, etc.) 14. Race - Ame Black, White			etc.
-	3XWidowed	4 Divorced	tf Yes, Give Year or Dates:		1	1 ☐ Yes 2XXNo Specify:					city: Wit	nite
Completed	(Spec	15. Decedent's E	de completed) (Give kind of work (rkina	16b. Kind of	Business/in-	dustry	
-	Elementary/Seco		College (1-4or	5+)	(Give kind of work done during most of working life. DO NOT use retired)				g	** . 1	D 1	
5		12		Bookkeeper 18. Mother's N								opment Cer
0	17. Father's Name)							, Maiden Sum	ame)	
0	Isadore I			Sadie Se							. 01.1. 71.	0.41
	19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town 19b. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or Town 19c. Melling Address (Street and Number or Rural Route Number, City or										C000)	
tant: If item jury or othe	Hyla Jaff		agircer)	20b. Pla	ce of Dispos	sition (Nan	ne of		Date		n - City or To	own, State
	1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Fe											
	21. Signature of Fu	5 Other (Special		Manc						Manche		
	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Capitol Funeral Services, Inc. 7211 Lee Highway, Falls Church, VA 22046											
	222 224 244	Wen 1	1000	tell)							VA ZZ	Approximete
	shook, or hear	rt failure. List only	one cause on each	line.	Do not ente	er (rie mou	e or ayın	g, such es cardia	c or respiratory	arrest,		Intervel Between Onset and Death
	Immediate Cause ((Final	<	Som	- 1						1	1 do
	diseese or condition resulting in deeth)		a	ep.	75							, only
Examiner			Due to (or as a consequence of):									1 day
	Comment of the state of		b	Due to for	as a consequ	D PU	a					1
	Sequentially list con if any, leading to im	nditions, nmediate		Duo 10 (0)	as a consequ	26/100 01).						
	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.											
physicie is the bu	that initiated events	l and	resulting in death) Last Due to (or as a consequence of):									
	that initiated events	Last		d							1	
Σ	that initiated events	Last	d								1	
Ξ	that initiated events resulting in death) I	Last	d	but not result	ing in the ur	nderlying c	ause giv	en in Part I.	23b. Dio	I tobacco use	contribute t	o the cause of dea
Σ	that initiated events resulting in death) I	Last	d	but not result	ing in the ur	nderlying c	ause giv	en in Part I.		tobacco use		o the cause of dea
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Physician/M	that initiated events resulting in death) I	Last	d	but not result	ing in the ur	nderlying c	ause giv	en in Part I.	1 = 24a. Wa		0 3 □ Pro	debiy 4 Unknown
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rnysiciarum	that initiated events resulting in death) I	Last	d	but not result	ing in the un	nderlying c	ause giv	en in Part I.	1 Z4a. Wa	Yes 2010	0 3 Pro	debily 4 Unknown
se completed by Physician/M	Part II. Other signif 25. Was case referencement?	licent conditions of	Homital		ing in the ur	nderlying c		26. Place of De	24a. Wa peri	yes 2 A	24b. W	dere autopsy finding ralleble prior to impletion of cause death?
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cologi col illication. To de completed ay chipating	25. Was case referrexaminer? 1 Yes 2 27. Menner of Deatt 1 Accident 3 Suicide 4 Homicide	red tormedical No h 5 Pending Investigatio 6 Could not be determined	Hospital: 1 Inpat 28a. Date of Inj (Month, Di 28e. Plece of Ir building, e	ient 2 E ury ay Year) ay Year) ay Year) ay Year) ay Year)	R/Outpatien 28b. Time of Injury ne, farm, stre	M 2 M occurred occurred estigation.	DA Oth Wor 1 y, office at the tin, in my o	26. Place of Deer: 4 Nursing yat k? Yes 2 No	24a. Wa period 24a. W	s an autopsy ormed? Yes 2 Moone) Idence 6 10 how injury occurrence (Street and Num, State) cause(s) and, date and place 29d. Date sig	24b. Way occord of 11	deebly 4 Unkn dere autopsy findin- ralleble prior to impletion of cause deeth? Yes 2 No
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Medical Certification: To Be Completed by Physician/Medi	25. Was case referencements of the control of the c	red to medical To To Pending Investigetio Could not be determined To Certifying Pr Could not be determined Till certifying Pr Could not be determined	Hospital: 1 Inpat 28a. Date of Inj (Month, Di 28e. Plece of Ir building, e	ient 2 E ury ay Year) njury - At hom fic. (Specify) of my knowl of examinatic fafed.	R/Outpatien 28b. Time of Injury ne, farm, stre edge, deeth and/or inv	M 22 M 2 Occurred occurred estigation.	DA Oth Wor 1 y, office at the tin, in my o	26. Place of Deer: 4 Nursing yat k? Yes 2 No	24a. Wa period 24a. W	s an autopsy ormed? Yes 2 Moone) Idence 6 10 how injury occurrence (Street and Num, State) cause(s) and, date and place 29d. Date sig	24b. Way occord of 11	Vere autopsy findin: valleble prior to mpletion of cause death? Yes 2 No No No No No No No No No No No No No



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year **Physician** 2000 February 23, 11:55 pm Reta M. Shay /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Wor of Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 15111 Glade Drive, 1D 5. Social Security Number 6. Sex Montgomery 5. Social Security Number If I Inder 1 Ye Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F Months Days 90 Oct 30, Director 118-10-1307 Canada Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiena. Important: if Nem 27 is marked other than "natural", or Nems 23s or 28s-f show say injury or other traumatic avent, the Wedfred Examination and be notified at page. 10a. State 10c. City, Town or Location 10b. County 10d Inside City Limits 1 ☐ Yes 2 No Director Silver Spring Maryland | Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 15111 Glade Drive, USA Funeral 1D 20906 12. Was Decedent Ever in U,S.
Armed Forces?
1 Yes 2 XNo
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 No Specify: Specify: White by 3 XWidowed 4 ☐ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Clerk Federal Government 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Richard Thomas Loughlin Emma Jane Putnam 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Neme/Relationship (Type, Print) Douglas Yeatman/ Executor 4405 East West Highway, 6th Floor, Bethesda, MD20814 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 Burial 2 □ Cremetion 3 □ Removel from State 2/29/00 Town of Watertown, NY 4 ☐ Donation 5 ☐ Other (Specify) Brookside Cemetery 22. Name end Address of Fecility 21. Signature of Funeral Service Licenses Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901

Renter the mode of dying, such as cardiac or respiratory errest,

Approximate Intervel Between Onset end Death 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, of heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as e consequence of): Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Minknown Anemia à 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes an autopsy 1□ Yes 21 No 1 Yes 20 No 25. Was case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Other: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Watural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State)

physician and the burlat-transit Box 68760. P.O. signed by i Records. Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director.

the Maryland

Baitimore, Maryland 21215-0020

3 Suicide

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

4 I Homicide

29a. Cartifier (Check only one)

29c. License number D53244 29d. Date signed (Month, Dey, Year)

30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

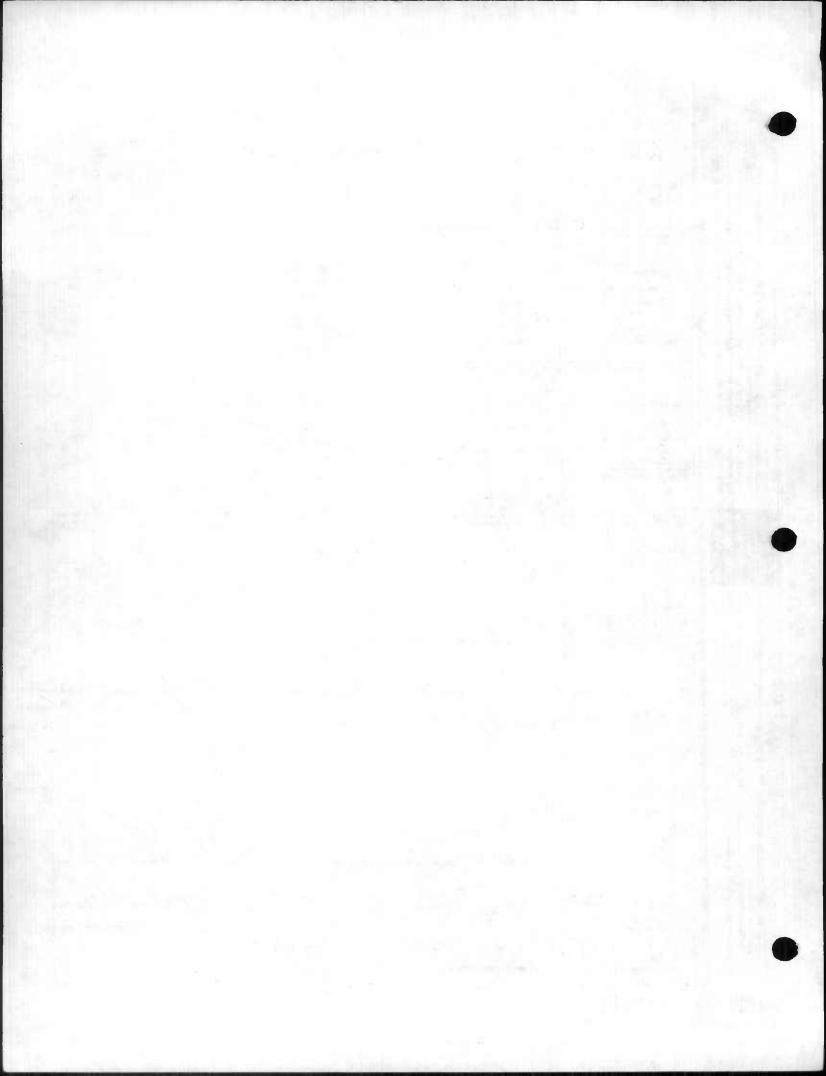
11140 Rockville Pike # 348, Rockville, MD 20852 MD Katharine 31. Dete filed (Month, Day, Year)

State Registrar

1>

Medical

32. Registrar's Signeture FEB 2 8 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Feb. 20, 2000 1:35 AM Shooshan, Jr. Manuel 1 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death North Bethesda Montgomery Brighton Gardens Retirement Home If Undar 1 Yaar | If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 9. Birthplaca (Stata or Foraign 1 XM 2 □ F Months Days Hours Yrs. 1918 8, Boston, Ma. 82 Jan. 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2 □ No Montgomery Chevy Chase 10f. Zip Coda 10g. Citizen of What Country? 5555 Friendship Blvd. U.S.A. 20815 12. Was Decedent Evar in U,S.
Armed Forcas?
1 (X) Yas 2 (1) No
If Yas, Giva
Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 Navar Married 2 Married White 1 Yas 2 No Specify: 3 XWidowad 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) Collaga (1-4or 5+) Elemantery/Secondary (0-12) U.S. Government Government Employee 18. Mothar's Nama (First, Middla, Maidan Sumama) 17. Fathar's Nama (First, Middla, Last) Esther Aslanian Harry M. Shooshan 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 12041 Great Elm Drive, Potomac, Md. 20854 Harry M. Shooshan 111 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 2/26/2000 Falls Church, Va. National Crematory 21. Signature of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. NW., Washington, D.C. 20016 23a. Part1. Enter the demand or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or hard the real cause on a each line. Approximeta Intarval Batween Onsat and Death I HOUTH . MALHUTRITUD / DEITERATION Dua to (or as a consequence of) 4 15125 DISENSIT ALZIICMET'S Dua to (or as a consequanca of)

Physician /Medical Examiner

and

the attending physician

signed by

this After

To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After

Box 68760.

P.O.

Division of Vital Records,

Physician

/Medical

Examiner

Funeral

Director

from 27 is marked other than "natural", or froms 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

pernit. Pages 1 and 2 should be filed within. Oppartment of Health and Mental Hygiene. Important: If Item 27 is marked other than "n any Injury or other traumatic event

the Maryland

Baltimore, Maryland 21215-0020

Harry

10a. Stata

Maryland

Directo

Funeral

by

Completed

Be

5. Social Security Number

032-05-3904 Usual Rasidence of Decedant

10e. Street and Number

20a. Mathod of Disposition

Immediata Causa (Final diseesa or condition rasulting in death)

Examiner as the bunal-transit Physician/Medical by Completed Be edical Certification: To

Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disaasa or injury that initiated avants resulting in daath) Last

Dua to (or as a consequence of):

	L	d				j.					
Part It. Other significan	t conditions of	ontributing to de	ath but not ra:	sulting in the unc	darlying	Causi	a givan in Part I.	23b. Did tobacco u		the causs of death?	
1236								24a. Wes en autops performed?	ava	era eutopsy findings ailabla prior to appletion of causa death?	
								1□ Yas 2¶	No 1E	Yas 2 No	
25. Was casa rafarrad	to medical						26. Placa of Dea	ath (Check only ona)			
axaminar?		Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing H						Homa 5 Residanca 6 Othar (Specify) home			
27. Mannar of Death 1 X Naturel 5 2 ☐ Accident	Pending Invastigation		f Injury c. Day Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yas 2 □ No	28d. Dascribe how injury	occurred	-101116	
3 ☐ Suicida 6 4 ☐ Homicide	Could not be determined	28a. Plece	of Injury - At t g, atc. <i>(Speci</i>	noma, farm, streetify)	et, facto	ory, of	fice	28f. Location (Street and City or Town, State)	Number or Rura	l Routa Number,	
			sis of axamina					a, and due to the cause(s) aurred at tha tima, data and			
29b. Signature and to	of certifiar				2	9c. Lie	cense number	29d. Data	signed (Month,	Day, Year)	

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completely

State Registrar

31. Data filled (Marin, Day, Year) FEB 29

Jerold M. Share, MD.

30. Name and address of

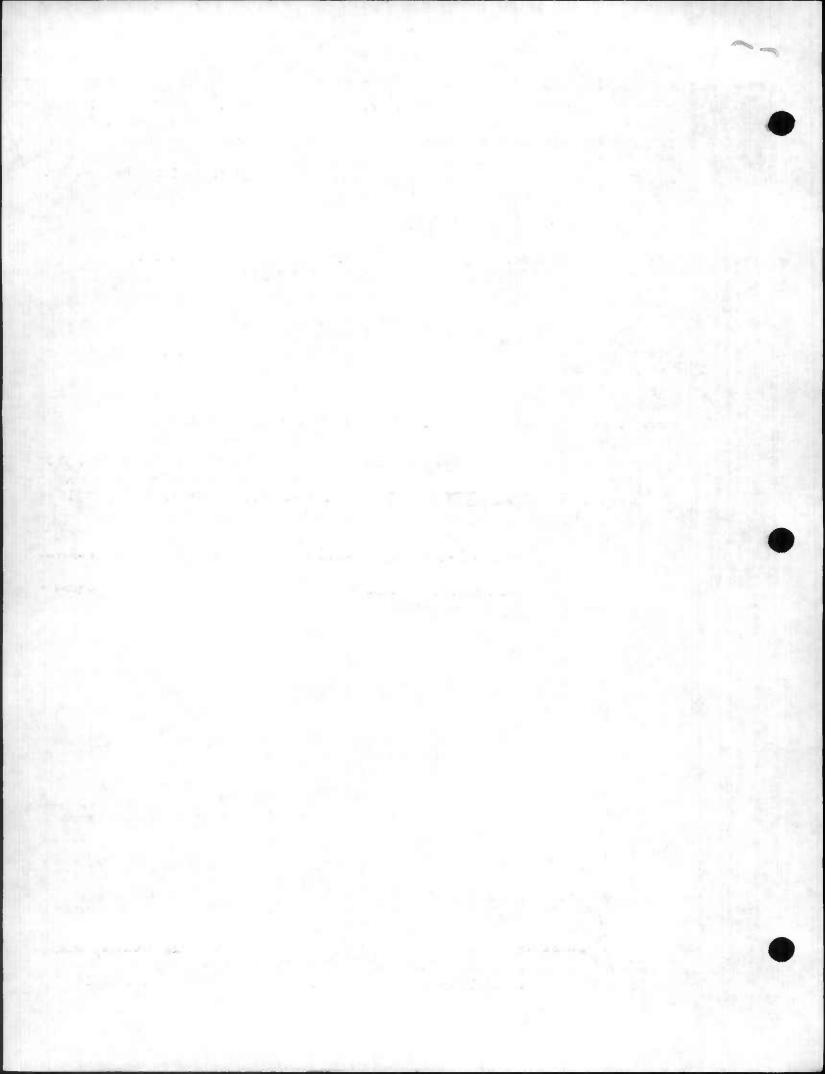
SLINRIZ MO

32. Registrar's Signatura

person who complated causa of death (Itam 23a) (Type, Print)

Sports

3301 New Mexico Ave. NW. #348, Washington, D.C. 20016



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 17, **Physician** Feb. 2000 9:55PM Lewis A. Sigler /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year)
May 26, 1909 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours M 2DF 90 Missouri 577604301 Director **Usual Residence of Decedent** the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f ahow 1 Yes 2 No Director MD Chevy Chase Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20815 USA 8101 Conn. Ave #407N Funeral 12. Was Decedent Ever in U.S. Agmed Forces? 11 Yes 2 □ No If Yes, Give Year or Detes: WWII 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian. Bleck, White, etc. 1 Never Merried 2 Merried White Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 5+ Attorney Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Be Elizabeth Inman Orvis Sigler 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Julia Friis/Step-Daughter 21658 116 Governors Way N, Queenstown, MD 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete PB Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Department of Important: If eny injury or 4 ☐ Donetion 5 ☐ Other (Specify) Gate of Heaven 022200 Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility CC-0378 Joseph Gawler's Sons 20016 5130 Wisc. Ave NW, Washington, DC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Betw Onset and Death **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Pneumonia Examiner Due to (or as a consequence of): Examiner Cerebrovascular accident physician end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of) 68760 Hypertension Physician/Medicai Due to (or as a consequence of): 88 Box P.0 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Congestive Heart Failure Records, Š 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an autopsy performed? Be Completed has i certificate ha 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital 25. Wes case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 🛱 ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Division or Attending t Ki Natural 5 Pending investigation deeth. 1 Yes 2 No 2 Accident ofter deet Director: 6 ☐ Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 Homicide filled In 24 hours edicai 29a. Certifier 1X Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and piace, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier Nathan MI D0053615 Feb. 17, 2000 2

Registrar

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32. Registrer's Signeture

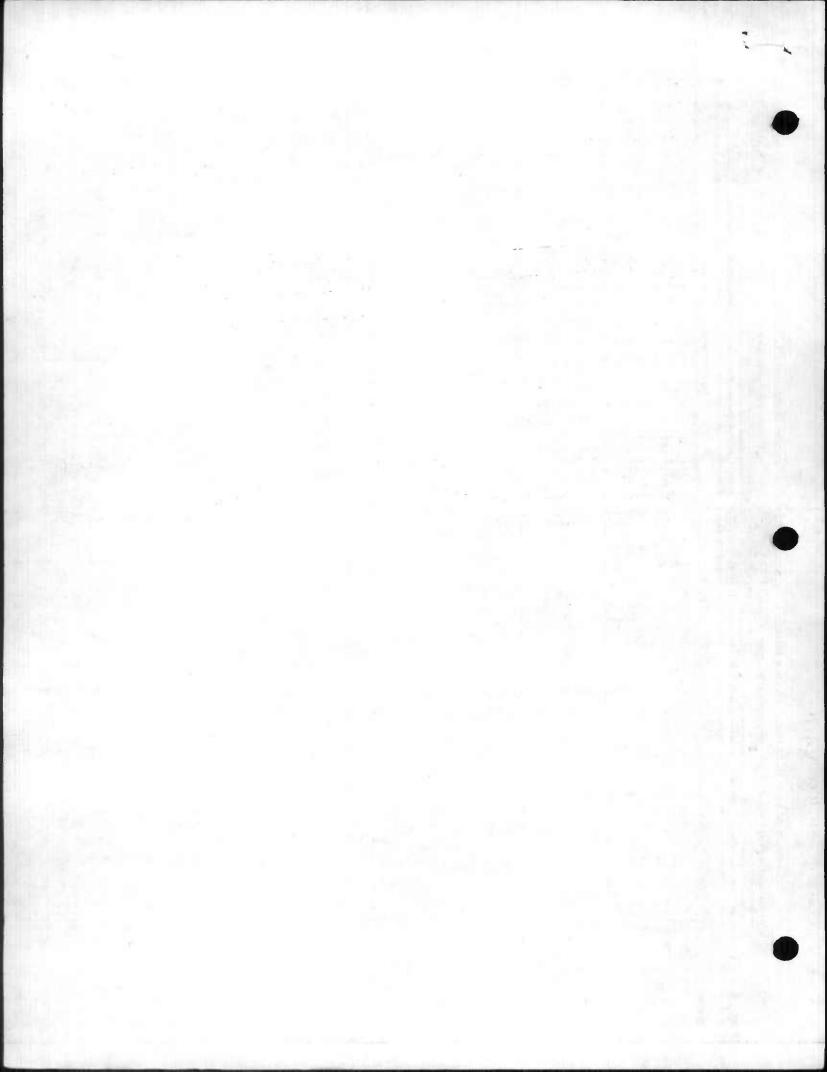
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nathan

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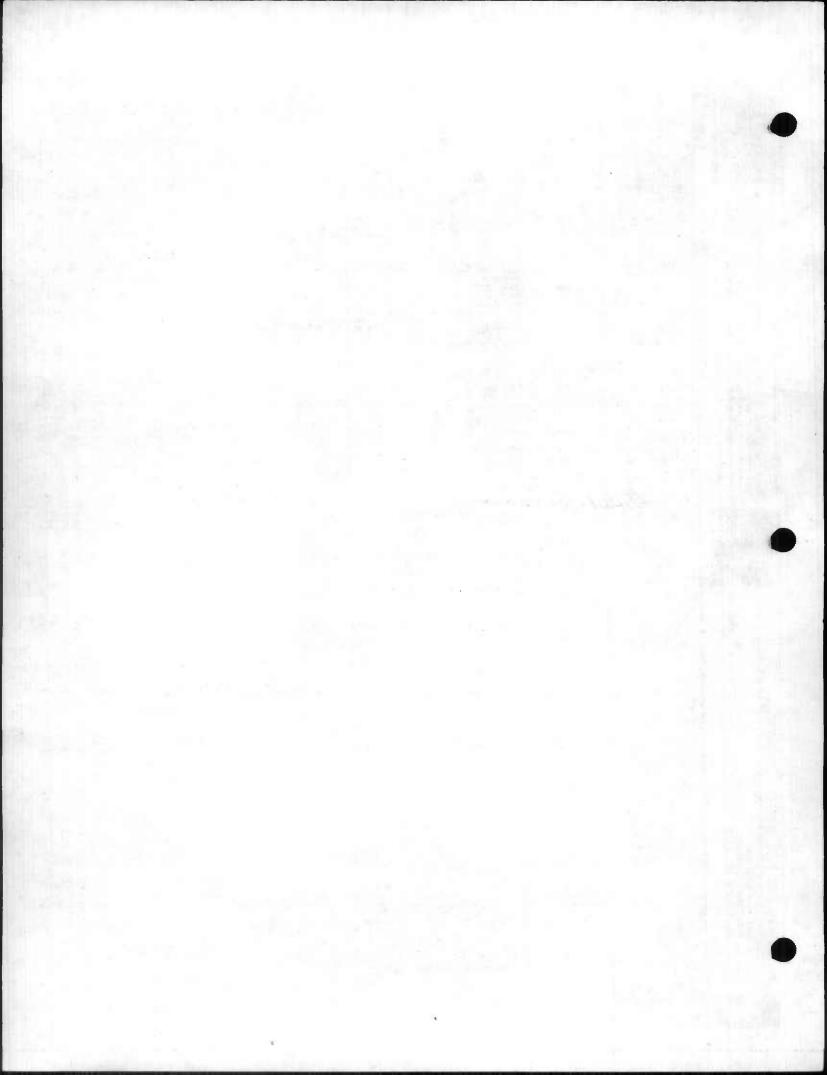
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State of Maryland / Department of Health and Mental Hygiene

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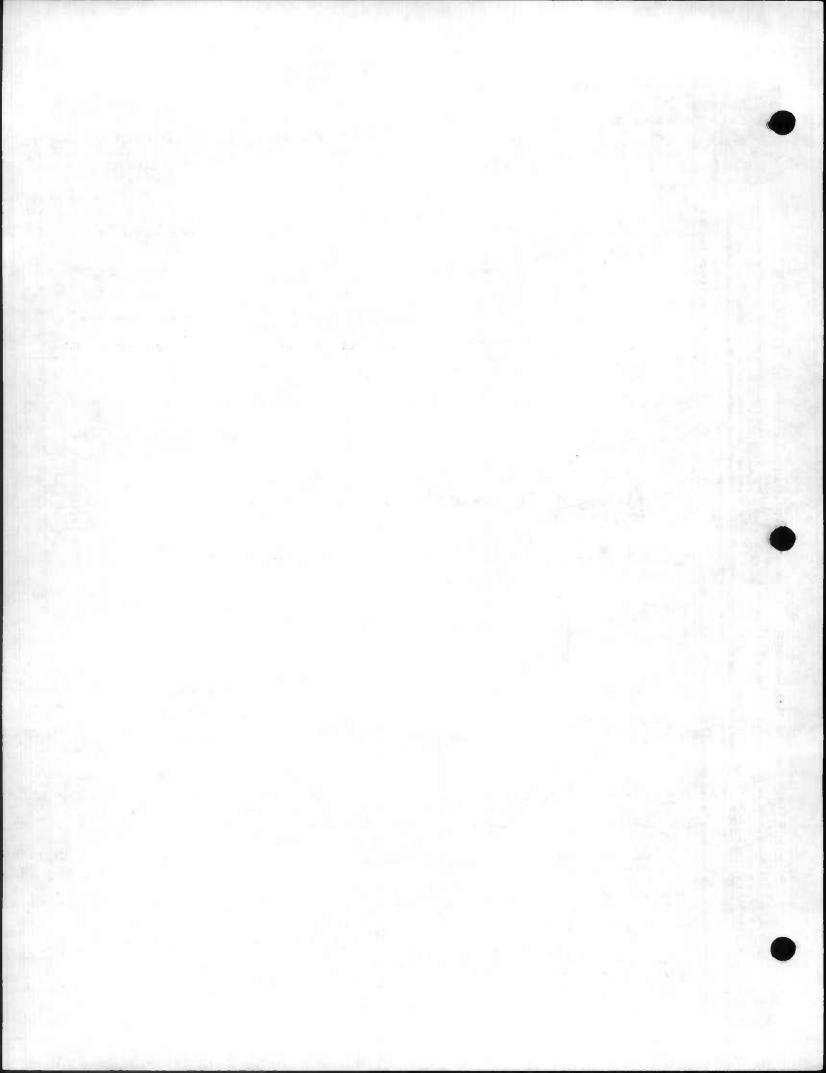
				Ce	rtificate	e of	Death			Reg. No.			
		1. Decedent's Name (First, Middle, L	ast)						2. Dete of De	eth		3. Tim	ne of Death
	Physician	Clarice Jul	ia Simms						Month	Dey	Year	1.0	F.0
9	/Medical	4a Facility Name (If not institution, g				-	lb. City. To	wn, or Lo	Februar cation of Death	y 28,20		1_10:	:50a.m.
	Examiner												
		Holy Cross Hosp: 5. Social Security Number 6.		rs. last birthday	1f Under	1 Yeer	SIII\		Spring		t gome		ate or Enreion
	Funeral		1 N 287 E		Months	Deys	Hours	Min.	8. Dete of Birt (Month, Da	y, Year)			ete or Foreign
	Director	578-50-7360 Usual Residence of Decedent	62						Jan. I.	2, 1938	Was	ning	ton DC
	B	10a. Stata 10b. County	10c.	City, Town or L	ocation						1	Od. Insid	de City Limifs
	or and	1 1 2 1										10	Yes 2⊠No
		Maryland Prince	e George's H	lyattsvi		0.4.				40- 02	110-11 0-11		
3	or 28s-f a be notified	10e. Street and Number		10f. Zip Code						10g. Citizen of What Country?			
	23 8	118 Manor Terra	ace				20785		United State				
-	72 hours ener death with the Maryland natural", or Nems 23s or 28s-f ahow deal Examinar must be notified at sted by Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?						cify Yes or No Rican, etc.)	- 14. Rad Bla	ce - Americ ick, White,		n,
2	2 E	1 Never Married 2 ☐ Married	1 Yes 2 No		1□ Yes						v: Bla		
2	by Fat.	3 ☐ Widowed 4 ☐ Divorced	Yeer or Detes:							Specif	y. Dia	CIC	
	"natural",	15. Decedent's (Specify only highest g		16a. Decedent's Usuel Occupation (Give kind of work done during most of working						16b. Kind of B	usiness/înc	dustry	-
V		Elementary/Secondary (0-12)		College (1-4or 5+)				i or works	''y				
7	be filed within tel Hygiens. Id other than event, the Es	12th		Nur	sing	Assi	stant	-		Heal	th Ca	re	
Maryland 21215-0020	- 5 0	17. Father's Name (First, Middle, Las	st)	18. Mother's I					(First, Middle,	Maiden Sumer	ne)		
	Mente Mente To E		Ross	oss (Unkn					m)				
	T a marked other the rearmetic event, to	19a. Informant's Name/Relationship	(Type, Print)	19b. Meil	ing Addrass	(Street	and Numbe	er or Rura	I Route Numbe	er, City or Town	, State, Zic	Code)	
ξ	permit. Pages 1 and 2 should by Department of Health and Monte Important: If Item 27 Is marked any Injury or other traumatic events.	Daniel Cimmo		110	Mana			17-		11- 1/3	207	0.5	
Ď .		Donald Simms 20a. Method of Disposition	206	. Plece of Disp		ne of			Date	20c. Location			
baltimore,		1 ☐ Buriaf 2√☐ Cremetion 3			matory or other piece) March					1,			
		4 Donation 5 Other (Specify) ChesapeakeCrematory Inc. 2								ReTts	ville	, Ma	ryland
0		21. Signature Funeral Service Uconcer 22. Neme and Address of Fecility RappFuneral and Cremation Service Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring											
-		Strah Date	huan		8555h	en I	Ave	irmar	n P.A.	ring. M	d. 20	910	
		23a, Pert1. Enfer the disease, or co	mplications thet caused the de	eth. Do not en	iter the mod	e of dyir	g, such es	cardiac o	or respiratory a	rrast,		Approx	imata I Between
P	hysician	shock, or heart feilure. List only one cause on each line.											and Deeth
	/Medical	Immediate Cause (Final Cardionul monary Arrest											
E	Examiner	disease or condition Cardlopulmonary Arrest esulting in death)											
	b		Dua to	o (or as a conse	quence of):						i		
3	# E		b. Multiorgan	-							i	2 W	leeks
_	end Frank	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dua to	(or as a conse	quence of):						i		
00100	clan burta	cause. Enter Underlying Cause (Disease or injury	. Metastatio	Ovaria	n Car	cino	oma				i	6 M	<i>fonths</i>
0	attending physician end for use as the burlat-transit clan/Medical Examiner	that initiated events resulting in death) Last	Due to	(or es e conse	quence of):						1		
O .	2										į		
	and and		G.										
. 1		Part II. Other significant conditions	contributing to death but not r	esulting in the	underlying c	ause giv	en in Pert I		23b. Did tobacco usa contribute to the cause of				use of death?
	though the								1 Yea 2 No 3 Probably				♦ □XUnknown
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necolds,	sen sign hould be ted b								24a. Wes	an autopsy	24b. W	ere autop	psy findings
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	Com Cata ha								10	Yas 2 № No	1[☐ Yes	XXNo
	this certificate ral director, pe	25. Was case referred to medical examiner?				1		of Death	(Check only o	ona)			
OI VICE	00 5	1 ☐ Yes 2XXNo		☐ ER/Outpatie	nt 3 DC	DA OIF	er: 4 Nu	ursing Hor	me 5 Resi	dence 6 🗆 Ot	her (Specif	ly)	
	eeth. lor: After th the funeral cation:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Tima of finjury	of 2	8c. Injur Wor	y at k?	1	28d. Describe	how injury occu	rred		
2	or deeth. ector: Afte by the fune	2 ☐ Accident investigati	on		М		Yes 2	No					
	2 2 2 E	3 Suicide 6 Could not determine		homa, farm, si	treet, lactory	, office		1	28f. Location (Street and Num	ber or Rure	al Routa	Number,
5	d de la	- Common	building, etc. (Spe	city					Only or rot	vii, Oluto)			
1	24 hours Funeral staty filled	29a. Certifier Certifying F	hysician: To the best of my k										
2	within 24 hours after to the Funeral Dir. completely filled in Medical Cert	(Check only 2 Medical Exp	aminer: On the basis of axami and manner stated.										ise(s)
-	within 2 To the comple	290. Signature and the of certifier	Ω Ω	1	290	. Licens	e number			29d. Dete sign	ed (Month,	Day, Ya	ar)
1	- 5 - 0	1 /1/ N	1 1	/ /	7	D522	261		February 29				
		ugany	Leon	w		JJLI	-01			repru	ary Z	2,20	.00
		30. Name and address of person who	/ /										
			299 Lamberton		Silve	r Sı	oring,	Md.	20902				
	State	31. Data filed (Month, Day, Year)	32. Registrar's Sig		- 1								
	Registrar	MAR U 3	2000 Jener	D.	10	ock	2/						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 4 45Am Month **Physician** Stella Sims 28 2000 2 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomer Bethesda Beth esos | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | All 8. | All 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Pennsylvania 201-24-2388 10 M 20 67 Yrs. Director Usual Residence of Decede the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show VA Warren Front Royal 1 Yes XXNo Director me 23a or 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or hams 23a or 22630 1403 Weaver Lane USA deeth Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White P 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry parmit. Pages 1 and 2 ahouid be filed within 1 Department of Health and Merial Hygieno. Important: If Nem 27 is marked other than 7s any Injury or other traumatic event. the Med Elementary/Secondary (0-12) College (1-4or 5+) Cafeteria Manager Public High School 12 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 George Herrington Hazel Casner 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Matthew L. Sims (Son) 14619 King Lear Ct. Silver Spring, MD 20906 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete 20c. Location - City or Town, Stete St. Mark's Episcopal Cem 3/1/00 Lewistown, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Metropolitan Funeral Service, Inc. otooldel 5517 Vine Street 22310 Alexandria, VA 23a. Part1. If there the disease, or comblications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart teilure. List only one cause on each line. Approximate Interval Between Onset end Death Physician METASTATIC SQUAMOUS CELL CARCINOMA OF /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner PERINEUN physician end s the buriei-fransk or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or es a consequence of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? been s Be Completed 24a. Wes an autopsy performed? page 2 s 1 Yes 2 No 1 Tyes 2 No certificate of Vitai director, 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 42 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation Division we Hospital or Attanding in 24 hours efter deeth. The Funeral Director: Africial pletely filled in by the fun 1 Netural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier Medical To the Hosp within 24 hor To the Fune completely fi (Check only 29b. Signature apa 29c. License number 29d. Date signed (Month, Day, Year) 28 0 death (Item 23a) (Type, Print) MD 4930 AVE, BETHESDA, MD 20814 31. Date filed (Month, Day, Year) histrar's Signature State FEB 29 2000 Registrar

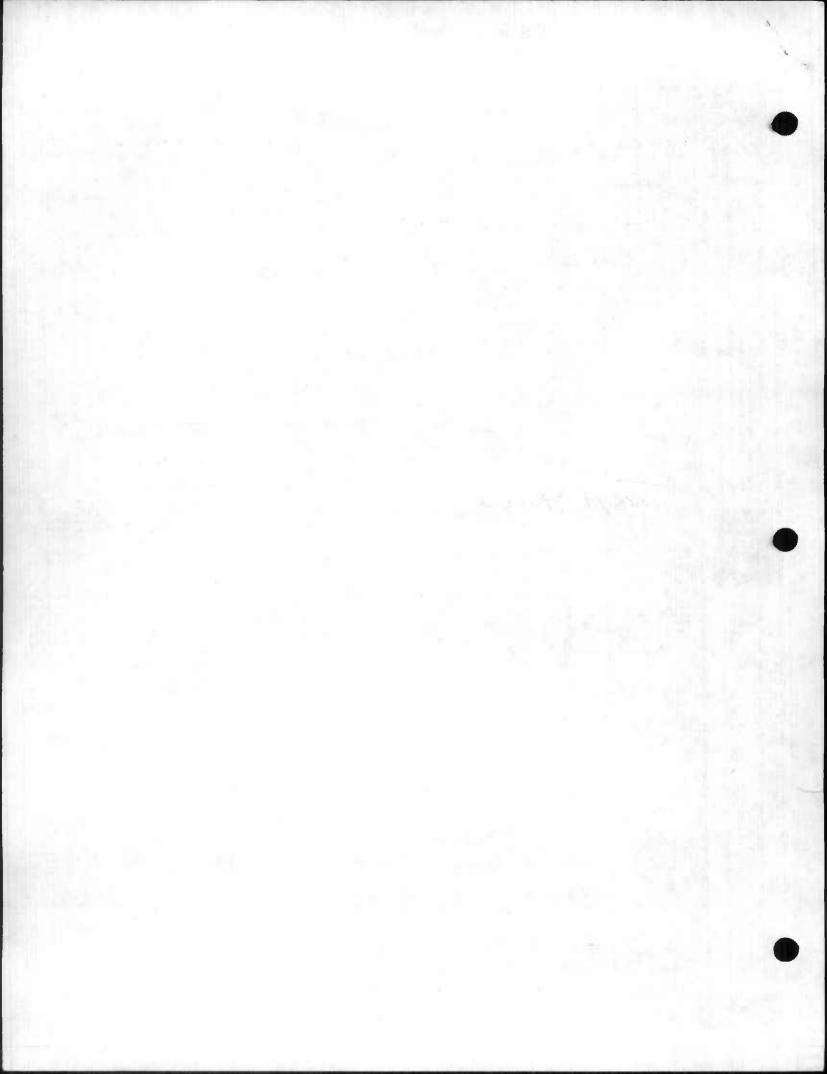


State of Maryland / Department of Health and Mental Hygiene 08546 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middla, Last) 3. Tima of Death Day Month **Physician** March 1, 2000 William Melville Smith 11:00 pm /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10104 Ashwood Drive Kensington Montgomery If Under 1 Yaer | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Hours Days Months 10 M 20 F Yrs 91 Mar 16, 1908 Director 579-14-2435 DC Usual Rasidence of Decedent 10a Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yas 2 No Director 28a-f Maryland Montgomery Kensington 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? thems 23s or intermed the m Funeral USA 20895 10104 Ashwood Drive 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, etc.) 14. Rece - American Indian, 12. Wes Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Giva
Year or Dates: ntal Hygiene, netural, or Item event, the Medical Examiner. Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 Tho Specify: Specify: þ White 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Building/ filed within Elementary/Secondary (0-12) College (1-4or 5+) Cabinet Making Owner/ Operator 17 Father's Name (First Middle Last) 18. Mother's Nama (First, Middle, Maiden Sumame) . Pages 1 and 2 about be fit the end Mental H tart: If Item 27 is marked other fury or giber transmits even Be William Floyd Smith Odessa Corella Snyder 19a. Intormant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Marie. A. Vermillion/ Daughter 12510 Littleton Street, Wheaton, MD 20906 20e. Mathod of Disposition 20b. Place of Disposition (Nama of cematary, cremetory or other place) Date 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Parklawn Memorial Park 3/6/00 Rockville, MD 21. Signature of Funeral Sarvice Licensee 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901
enter the mode of dying, such as cardiac or respiratory errest,
Approximate Interval Between Onset and Deeth Tuver 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or haart tailure. List only one cause on each line. **Physician** Immedieta Causa (Final diseasa or condition resulting in death) /Medical . Ventricular Fibrillation minutes Examiner Due to (or as a consequence of) Examiner sician and burial-transit Coronary Artery Disease vears The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es a consequence of) physician the burial Box 68760. Physician/Medical Dua to (or as a consequence of): 88 for use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown signed t Prostate cancer Records. þ 24b. Ware autopsy tindings available prior to completion of cause of death? pege 2 should Completed 24a. Was an autopsy performed? certificate has 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital Physician: 25. Was case referred to medical axaminer? Be 26. Placa of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Homa 5 AResidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ KNo this funeral 27. Mannar of Death 28b. Tima of Injury 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? After or Attending 5 Pending invastigation 24 hours after death.

Funeral Director: Al 1 Tyes 2 □ No 2 Accident 6 Could not be 3 Suicida Location (Street end Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

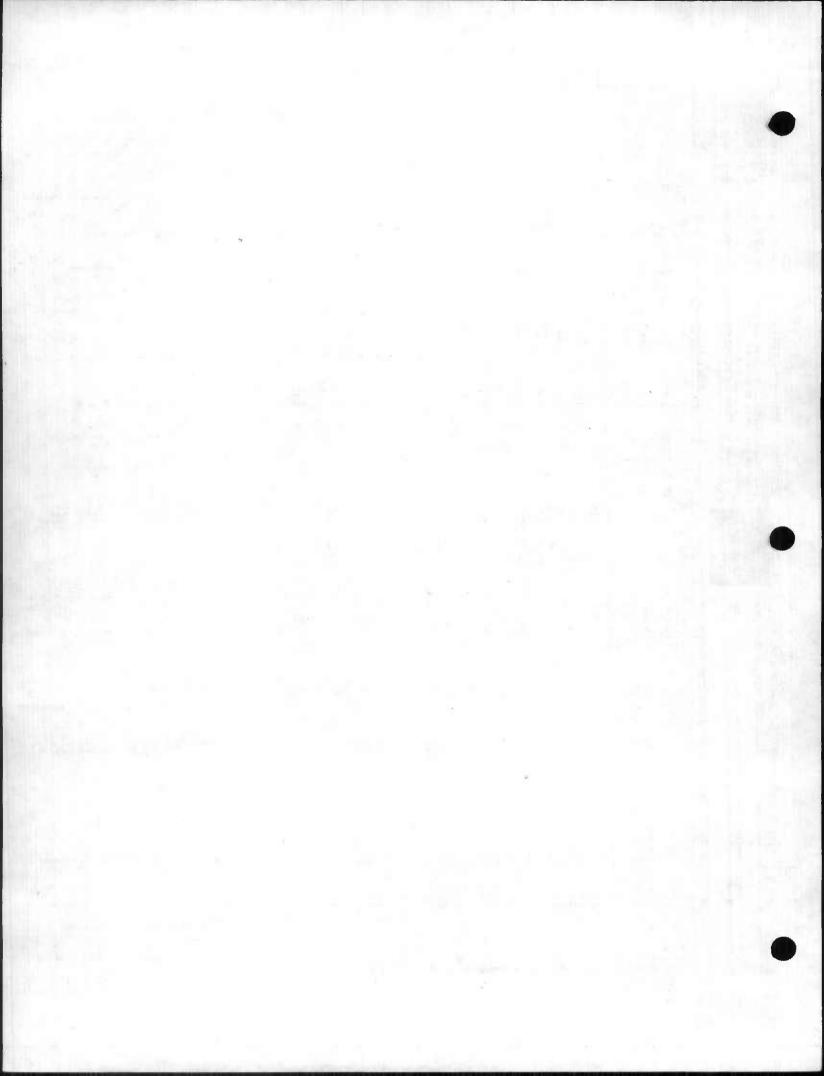
2 Medicat Examiner: On the bests of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Cartifier completely (Check only one) within 2 To the 29b. Signeture end titla of certifier 29c. Licanse number 29d. Data signed (Month, Day, Year) Zewie Malile MD D 05256 March 2, 2000 10 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) 6000 Executive Blvd., Rcokville, MD Lewis N. Cahill, MD 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State MAR 0 3 2000 oaks Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

						Cer	tificate of	Death		Reg. No.	, 00	U854.		
		1. Decedent's Nam	ne (First, Middle,	Last)					2. Dete of I	Death Dey	Year	3. Time of Death		
Phys	ician dical	Bessie T	Sperop	ulos						ary 27,		6:15 pm		
	niner			give street and numb	er)			4b. City, Town,	or Location of De		ty of Deeth			
9.0		Washingto	on Adven	tist Hosp:	ital			Takoma I	Park	Montg	omery	7		
Funer	al	5. Sociel Security			Age (In yrs. las	f birthday)	If Under 1 Year Months Deys		rs. 8. Dete of E	8. Dete of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)				
Direct	or	579-50-9 Usuel Residence		1 L M 20 F	92	Yrs.	Wichard Doys	110013	Nov 2	4, 1907	Gree			
Mand Mand		10a. Stete	10b. County		10c. City,	Town or Lo	cation	1000				10d. Inside City Limits		
Man	to	Maryland	Montgom	erv	Silve	er Sp:	rino					1 ☐ Yes 2 No		
r 28a	Director	10e. Street and Nu			DIII	or op.	10f. Zip Code			10g. Citizen of What Country?				
3a o		10005 Ra	mor Roa	d		20901					USA			
deati	Funeral	11. Meritel Stetus	ynor nou	12. Was Decede		13. y		Hispanic Origin?	ispanic Origin? (Specify Yes or No- in, Mexican, Puerto Rican, etc.)			ican Indian,		
flaryland 21215-0020 2 should be filed within 72 hours after death with the Maryland and Mental Hygisne. In marked other than "natural", or from 23a or 28a-f show sumatic avent, the Westerl Examiner must be notified at	by	1 ☐ Never Mer 3 ☐XWidowed	ried 2 Marrie	Armed Force d 1 Tyes 2 If Yes, Give Year or Dete	No		Yes, specify Cul		erto Hican, etc.)		eck, White ify: White			
2 ho	ted	10-1	15. Decedent's	Education		16a. Deced	lent's Usuel Occu	pation	and in	16b. Kind of	Business/II	ndustry		
ire, Maryland 21215 s 1 and 2 should be filed within 7 tf Health and Mental Hygiens tf Health and Mental Hygiens other traumatic avent, the Weal	Completed	Elementery/Sec		grade completed) College (1-4	or 5+)	life. L	OO NOT use retin	during most of ved)						
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and and		19e. Informent's N	leme/Relationshi	et and Number or	Rural Route Nun	nber, City or Tow	n, State, Zi	p Code)						
- B= 7.2		James T.	Speropu	los/ Son		1000	5 Raynor	Road, S	Silver S	oring, M	D 209	901		
TO Page and o part o y or I		20e. Method of Dis			20b. Plac	ace)	Dete	20c. Location						
			☐ Cremetion 3	Removal from Ste	910		Cemeter		3/2/00 Washington, DC					
Baltin permit. F Departmi Importan	•	21. Signeture of F	unerel Servica Li	cansee /		22	. Name end Addr	ess of Facility	1					
W SOF	D Per L	1 01	1.00.	16.11				. Collin						
		23a Part1 Enter	the disease or o	omplications that cau	sed the death	Do not ente	UU Unive	rsity Bl	liac or respiretory	Silver	Sprin	ng, Md 2090.		
Observatoria		shock, or he	ert feilure. List o	omplications that cau nly one cause on eac	h line.					0.100.,		Interval Between Onset and Deeth		
Physicia /Medica		Immediate Cause	(Finel	100	a d a	TIO	. 0	1221	MC2 M	A				
Examine		diseese or conditi resulting in deeth)	iseese or condition											
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pet is	듣			b. (1)	FONI	2 0	137716	UCTI	1 F PC	THON	6	1-earn		
I Records, P.O. Box 68760, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	Sequentially list or if any, leeding to it cause. Enter Und Cause (Disease of that initiated event	onditions, mmediete		Due to (or a	s e conseq	uence of):	c A 2 -	E 01	1000	1E			
60 be be	ie i	Cause (Diseese o	erlying r injury	c. CUN	CFZ	710	1 6 4	FAKU	LMI	COKE	1			
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ds, P.O. Box nires that the death cert signed by the attendin id be detached for use	by Physician/M										1			
O she she	ysi	Pert II. Other signi	ficant condition	s contributing to deat					23b. Di	d tobacco use o	ontribute	to the cause of death?		
P.O. hat the od by the detache	듄	C11 2.	24nc	Y ARTY	612 Y	01	,561	ATE	10	☐ Yes 2☐ No	3 □ Pro	obably 43 Unknown		
of Vital Records, Physician: The law requires the conflicate has been signed real director, page 2 should be conflicated.											Tour V	Man autono dia dia a		
v requir	Completed	14.6							24e. W	es an autopsy rformed?	8	Vere eutopsy findings vailebla prior to completion of cause		
Rec e law	hpie										0	death?		
Hete here	No.								10	Yes 28 No	1	☐ Yes 2☐ No		
f Vital Re ysician: The la is certificate ha director, page	Be (25. Wes case refe	rred to medical					26. Place of C	Death (Check on)	y one)	1			
of Vita Physician: this certific ral director,	To	exeminer?	No	Hospitel: Inp	atient 2 EF	VOutpetien	t 3D DOA	ther: 4 Nursing	Home 5 Re	sidence 6 🗆 O	ther (Spec	ify)		
On Of Iling Phys After this funeral di		27. Menner of Dee		28a. Dete of 1	Injury Day Year)	Bb. Time of	28c. Inju	ury at ork?	1	e how injury occ				
Or ath. "Ath	atio	Neturel 2 Accident	5 Pending Investige		Day (bai)	Injury		Yes 2□No						
Division or Attending after death. Director: After Jin by the fune	Hic	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	ed 269. Pieca of		e, ferm, stre	eet, factory, office		28f. Location	(Street and Nur	nber or Ru	ral Route Number,		
Dia pate	Certification:	4 Hornicide		building	, etc. (Specify)				City or I	own, State)				
Division To the Hospital or Attending within 24 hours after dealing To the Funeral Director: After completely filled in by the fune		29a. Certifier	Certifying	Physician: To the be taminer: On the basis	est of my knowle	dge, deeth	occurred at the t	time, date end pla	ice, and due to th	e cause(s) and	nenner es	stated.		
Ho Fu Fu	Medical	(Check only one)	2 ☐ Medicat Ex	caminer: On the basis and menner		end/or inv	restigetion, in my	opinion, deeth oc	curred et the tim	e, date and place	, and due	to the cause(s)		
om the	×	29b. Signeture end	title of certifier				29c. Licer	nse number		29d. Date sign	ned (Month	, Day, Year)		
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	tate			1000	istrer's Signetur	4	1	, .						
Regi	strar	IVI	WL AT 7	.000	-	D.	poork	1						

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Clayton E. Staton February 24, 2000 1:26 A.M. /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Yeer 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 MM 2□ F 59 224-58-5719 23, 1940 North Carolina Director Nov. Usuel Residence of Deceden the Maryland 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits Herne 23a or 28a-f ahow ther must be notified at 1 Yes 2 No Director Montgomery Md Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2405 Glenallan Avenue 20906 Funeral United States death 12. Wes Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 14. Raca - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after Specify: African 1 Never Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: by 3 Widowed 4 Divorced American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) . Pages 1 and 2 should be filled wi tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic avent, the 12 Xerox Technician Laboratory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle Maiden Surname) Be Unavailable Ada Pearl Council 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2405 Glenallan Avenue, Silver Spring, Md. 20906 Liz M. Thorne 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Mar. 1, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Department of Important: If any injury or pace. 4 ☐ Donation 5 ☐ Other (Specify) 2000 Gate of Heaven Silver Spring, Md 21. Signature of Funerel Service Licensee 22. Name end Address of Facility
MCGUIRE FUNERAL SERVICE, INC. Kellsberry Hound /CC0394 7400 Georgia Ave., N.W. Washington, D.C. 20012 23a. Part. Enter the disease, or complications that baused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final 6 hours disease or condition resulting in deeth) Cardiogenic Shock Examiner Due to (or as a consequence of): Examiner Acute Myocardial Infarction days physician and the burial-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of): Box 68760, Physician/Medical Due to (or as a consequence of): 158 ò Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? the signed by t 1 Yes 2 No 3 Probably 4 Unknown Chronic Renal Failure Records, þ 24b. Were autopsy findings available prior to completion of cause of death? been si 24a. Was an autopsy performed? Completed page 2 s 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: director. Be 25. Wes case referred to medical axaminer? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Netural 2 ☐ Accident death. 1 Yes 2 No within 24 hours after death To the Funeral Director: completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner es stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) February 24, 2000 D20400 woen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mark S. Rosen, M.D. 3941 Ferrara Drive Wheaton, Md 20906 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State

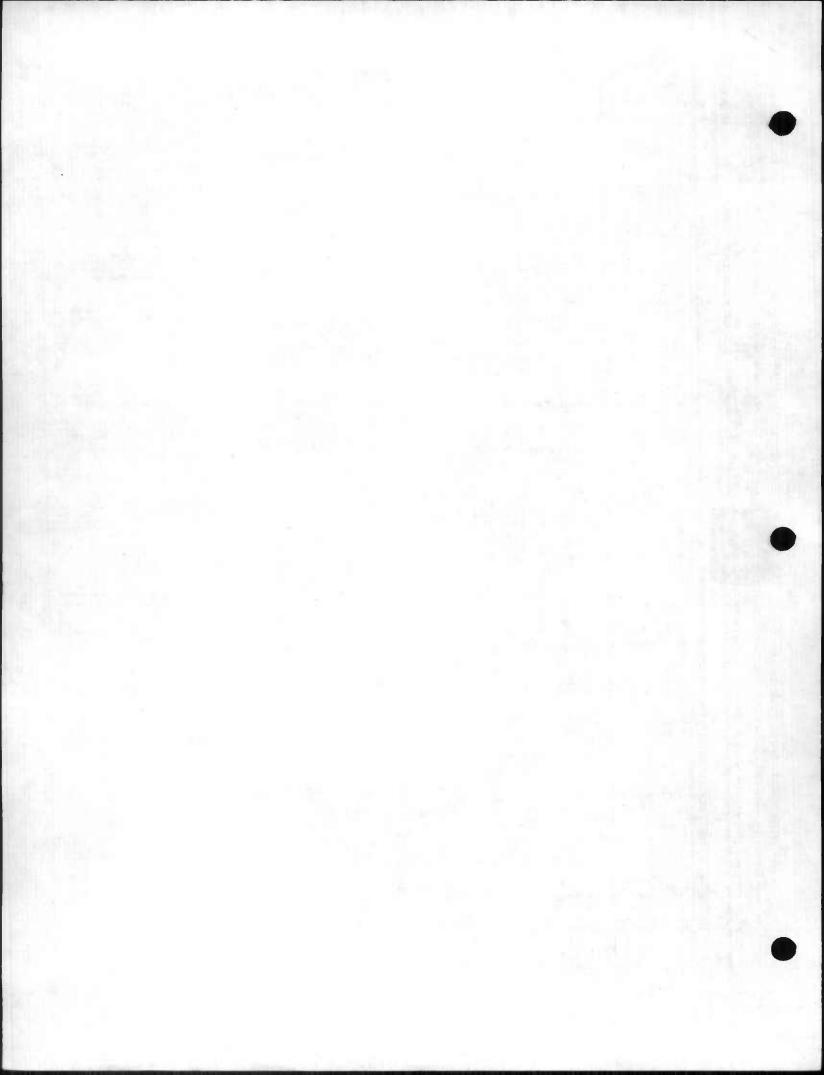
DHMH 16 Rev 6/95

Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend #8,3/3/2000 RMW, Montg. Co. . Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:35 PM SARAH E. STEWART FEB. 28, 2000 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Springbrook Nursing & Rehab Center Silver Spring MONTGOMERY If Under 24 Hrs. 8. Date of Birth 1915 May 20 1916 7. Age (In yrs. last birthday) If Under 1 Year Months Days 9. Birthplace (State or Foreign Country) Maryland 6. Sex **Funeral** Hours 1□M 2□XF 220-12-3101 84 Director Usuei Residenca of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Silver Spring MD Montgomery Directo 25a-f 10g. Citizen of Whet Country? 10e. Street end Number 10f. Zip Code ò 20902 U.S.A. 1135 University West, #901 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Merried 21215-0020 8 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Home Domestic 7th Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Pages 1 and 2 should be filment of Health and Mental Hamt of Health and Mental Hamt (If them 27 is marked off jury or other traumetic even Be Blanche Hodge Unknown 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 10508 Huntley Pl., Silver Spring, MD 20902 Leslie Jackson (Niece) 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20e. Method of Disposition cemetery, cremetory or other plece) ₩ Buriel 2 Cremetion 3 Removel from State 3/7/00 Sandy Spring, MD Ash Memorial Cem. 4 ☐ Donetion 5 ☐ Other (Specify) ature of Funeral Service by 22. Name and Address of Fecility
SNOWDEN FUNERAL HOME, P.A. 20850 ROCKVILLE, MD o or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel Gangrene 2 mos disease or condition resulting in death) Examiner Examiner Vascular many Dheral yrs physician and s the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es a consequence of) Box 68760, Physician/Medical Due to (or es e consequence of): Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? O 1 Yes 2 No 3 Probably 4 Unknown 0 Anemia. Records. þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? The 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 29a. Certifier edical To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner steled. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certified 1) 31001 2/29/00 Catr. Dr. #430 30. Neme end address of person who completed gause of death (flem 23a) (Type, Print) 7500 Green way

Registrar

M.D.

Kerri Y

32. Registrer's Signature

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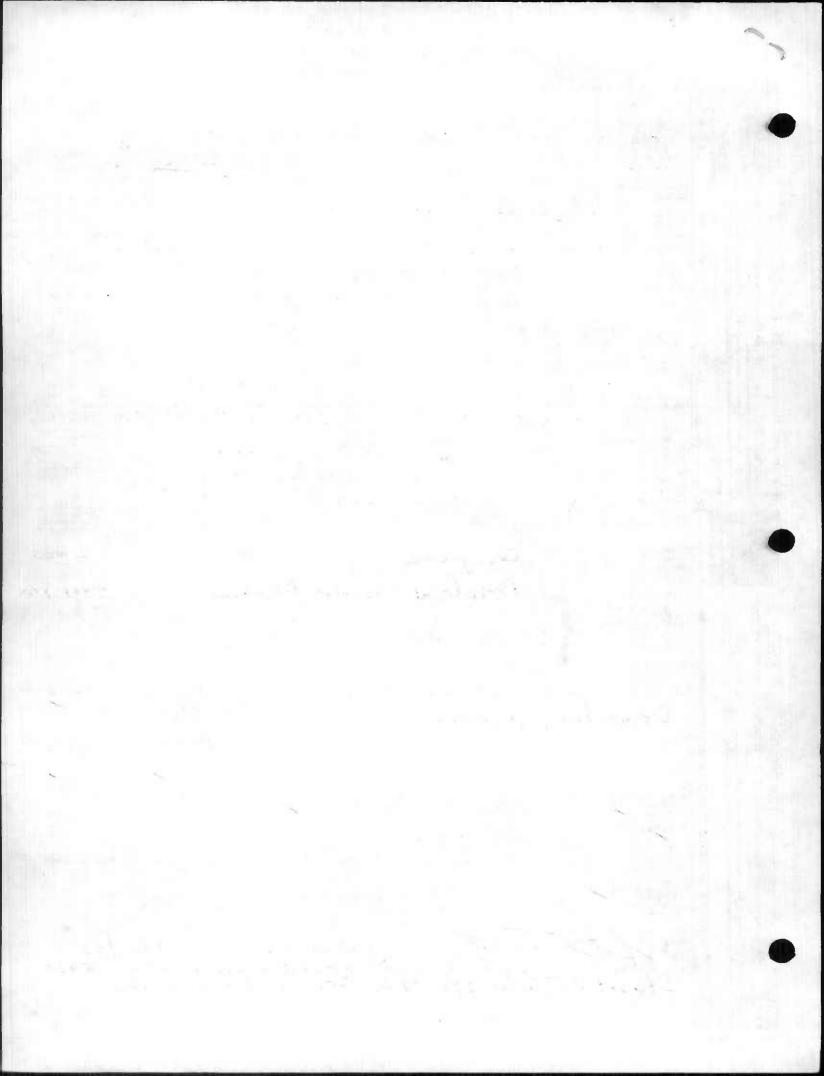
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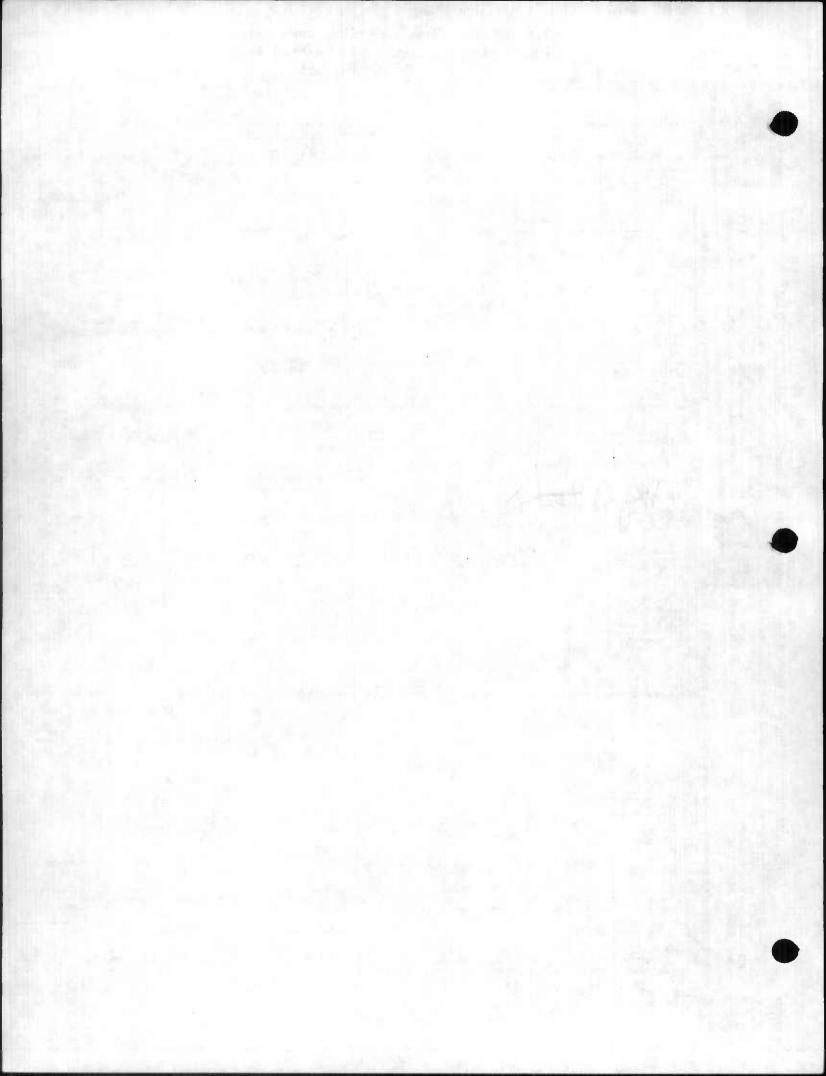
Greenfelt, MD.



State of Maryland / Department of Health and Mental Hygiene

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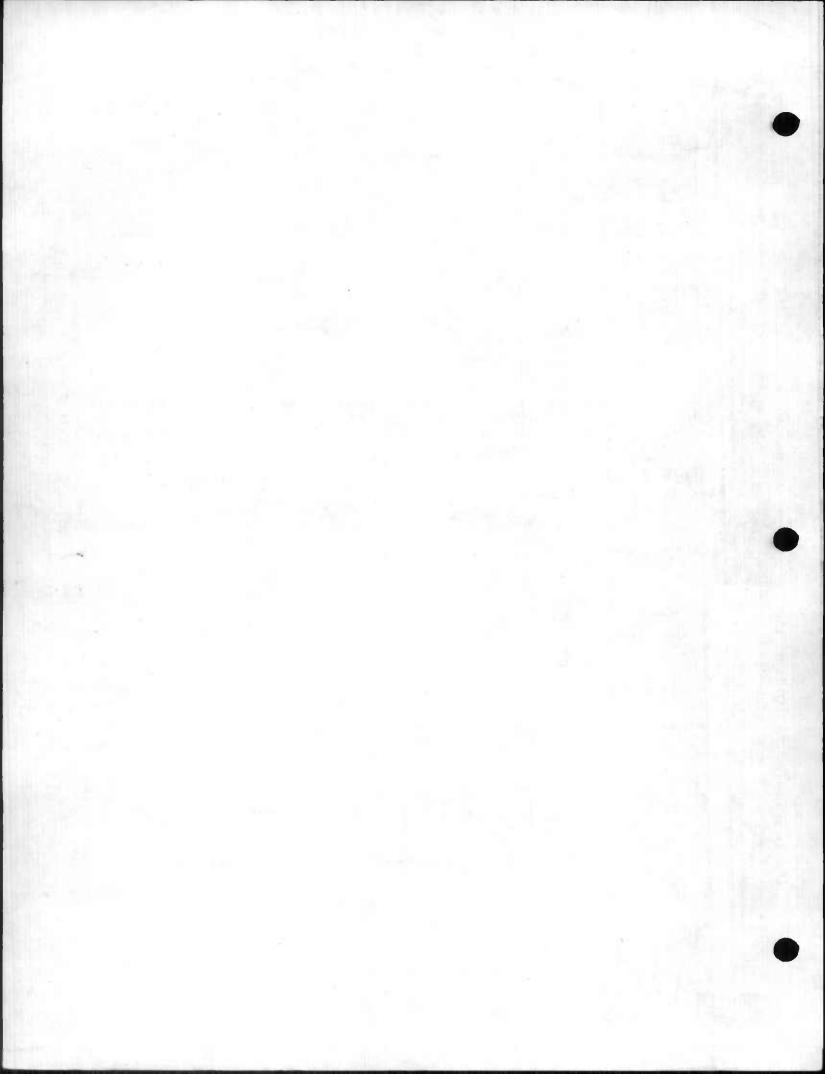
			(Certificate of	f Death		Reg. No.		
	1. Decedent's Nama (First, Middla, L.	ast)	24.00	CARD HE		2. Data of D		Vans	3. Time of Death
Physician	Charles Gilbert	Stine				Februa	ry 24, 2	Year 000	2:05 PM
/Medical Examiner	4a Facility Neme (If not institution, girls SHADY GROV	ve street and number)	IST HOS	SPITAL		or Location of Dea	th 4c. County		
Funeral Director		Sex 7. Age 1	(In yrs. last birth	Months Day		Hrs. 8. Date of B. (Month, D. March 5		9. Birthpi Coun Mary.	lace (State or Foreign try) Land
¥ k.	10a. Stata 10b. County	,-100	10c. City, Town	or Location				11	0d. Inside City Limits
or 28arf sho be notified a	Maryland Montgom	ery	Rockvi				40-00041		1 ☐ Yes 2 ☑ No
	10e. Street and Number 15221 Bitterroot	Way		10f. Zip Code 2085	3		10g. Citizen of V	d Sta	ites
	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forcas? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☒ N		? (Specify Yes or Nuerto Rican, atc.)	No- 14. Race - Amarican Indian Black, White, etc. Specify: White		etc.
5-0 72 72 72 72 72 72 72 72 72 72 72 72 72 72 72 72 7	15. Decedent's E (Specify only highest gr		16a. C	Decedent's Usual Occ Give kind of work don	upation	working	16b. Kind of Bu		
Maryland 21215-0020 12 should be filed within 72 hours at 12 should be filed within 72 hours at 12 marked other than "natural", or traumetic event, the Medical Exam To Be Completed by 1	Elementery/Secondery (0-12)	College (1-4or 5+	Di	ire. DO NOT use reli rector of nancial Se	red)	Working	Montgome Public		
De file to othe event,	17. Fathar's Nama (First, Middla, Las	()				Nama (First, Middle	e, Maiden Surnam	ie)	
ylar Menta Menta stic es	J. Gilbert Stine				Nellie	e Gutshal	1		
2 show	19a. informant's Name/Relationship	(Type, Print)	19b. I	Meiting Address (Stre	et and Number o	r Rural Route Num	ber, City or Town,	State, Zip	Code)
S pod 5	Geraldine Stine/	Wife	153	221 Bitter	root Way	y, Rockvi	lle, Mar	yland	20853
Baltimore emit. Pages 1 i appartment of He important: if them ny injury or other nos.	20e. Method of Disposition 1 ⊠ Burial 2 □ Cremation 3 [4 □ Donation 5 □ Other (Special Service) Lice	ify)	cemetery,		1 Park lress of Facility]	Feb. 29, 2000 Robert A.	Rockvil Pumphre	le, M	Maryland Meral Home
00 18558	23a Part Epin the disease, or con	M00		Rockville Ro t enter tha mode of d	ckville.	300 West Marylan	d 20850-		Approximate therval Between
Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	· METAST		ARCINO					Onset and Death 2 MONTHS
box 68760, death certificate be executed e attending physician and ad for use as the bunal-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseese or injury that initialed events resulting in death) Last	C	Oue to (or as e co						
that the death celed by the attendir detached for use	Pert II. Other aignificant conditions	contributing to death but	t not resulting in t	the underlying cause	given in Part I.		I tobacco uae con		the cause of death?
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The law ate has page 2						1□	Yes 20 No	10	Yes 2□ No
r Vital Riving Stellan: The I	25. Was case referred to medical				26. Place of	Death (Check only	one)		
Of Vita Physician: this certific ral director,	examiner?	Hospital:	t 2 ER/Out	patient 3 DOA	Other:	ng Home 5 □ Res		er (Snecif	vl
After thi funeral	27. Menner of Death 1 Natural 2 Accident 3 Suicide 6 Could not	28a. Dete of tnjury (Month, Day	Year) 28b. Tii	me of ury M 1	jury at łork? □ Yas 2 □ No	28d. Describe	how injury occurr	red	
Division And Ital or And Ital or And Ital or And Ital Direct Ital Ital Ital Ital Ital Ital Ital Ita	4 Homicide determined	building, etc.	(Specify)	n, street, fectory, offic		City or To	(Street and Numb own, State)		
Divising to the Hospital or Attended within 24 hours after deat To the Funeral Director: completally filled in by the Medical Certifical	(Check only 2 Medicai Exa	hyaician: To the best of miner: On the basis of a and manner state	examinetion end/	death occurred at tha or investigetion, in my	time, date and p y opinion, deeth	plece, end due to the occurred at the time	, dete end ptaca,	and due to	the cause(s)
To the com	29b. Signatura and titia of certifier		1	29c. Lice	nse number		29d. Date signer	d (Month,	Day, Year)
2011	30. Name and address of person who	completed cause of de	lui)	DO Print	17285		FEBRUAR	724	12000
277	JAMES A. BROW	79 EM 40	07 MED	CAC CANTE	R. DRIVE	5, ROCKEN	ut, MI	20	6780
State Registrar	31. Data filed (Month, Day, Year) FEB 2 8 2	32. Registrar	s Signature	. Sport	/w				



State of Maryland / Department of Health and Mental Hygiene

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			Certi	ficate of	Death		Reg. No.			
	1. Decedent's Name (First, Middle, Las	1)				2. Dete of Dec		Vaar	3. Time of Deeth	
Physician /Medical	Herbert Henry Su	hr					y 23, 2	2000	7:45 PM	
Examiner	4e Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death	4c. County	of Death		
	Suburban Hospita	1			Bethesda		Montg	gomery	7	
Funeral Director	06/-0/-4460	7. Age (In yrs. 87	Mast Duringal/	f Under 1 Year fonths Deys	If Under 24 Hr Hours Mir		, Year) 1912	9. Birthp Coun New Y	leca (Stete or Foreigr try) Ork	
with the Maryland as or 28a-f show Lbe notified at I Director	Uaual Residence of Decedent 10a. State 10b. County	10c. C	ity, Town or Locat	ion				1	0d. Inside City Limita	
o Ma	Maryland Montgomery Bethesda									
or 28a-fr	10e. Street and Numbar			10f. Zip Code			10g. Citizen of 1	What Coun	try?	
W Call	5225 Pooks Hill Ro	ad #222S		20814			United	State	ès	
ors after death with the Marylar uns after death with the Marylar sis, or thems 22a or 28a-7 show Examiner must be notified at by Funeral Director	11. Meritel Stetus 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 (X) Yes 2 □ No If Yes, Give Yeer or Dates: WWI	10	s Decedent of I es, specify Cub Yes 2 🗓 No		Specify Yea or No- rto Rican, etc.)		ck, White, White, White	etc.	
ted train	15. Decedent's Ed		16e. Deceden	t's Uaual Occup	pation		16b. Kind of B	uainess/inc	duatry	
ad within 72 ho organia. we than "natura it, the Medical. Completed	(Specify only highest grade Elementary/Secondery (0-12)	College (1-4or 5+)	life. DO	NOT use retire	during most of w	orking				
and and and		2	Manage	r			Retail	L		
the file of other event	17. Fether's Neme (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Meiden Sumer	ne)		
thould be the Markel of marked of marked of To Be	Christian Suhr				Frieda (Grefe				
	19a. Informent's Name/Reletionship (7		19b. Mailing A	Address (Street	end Number or F	Rural Route Number	r, City or Town,	, Stete, Zip	Code)	
CENL	Patricia R. Toth/s	tep daughter	33 Rob	erts C	ircle, Ba	asking Ri	dge, N.	J. 07	7920	
or other	20a. Method of Disposition 1 🖾 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	Hemover from State	Place of Disposition cometery, cremeter ional Me			Feb. 26,	20c. Location Falls Cl		wn, Stete , Virginia	
permit. Pa Department Important: any injury ance.	21. Signature of Funeral Service Lisen.		22. N Bethe	ame end Addresda-Chev	ess of Fecility RC	bert A. Punc. 7557 W	mohrey Fu	neral	Home/	
Physician /Medical Examiner	23a. Part1. Enter-the disease, or companock, or heart feiture. List only of the companion o	a. Respira	tory Fai	lure				7	Approximate Interval Between Onset and Deeth	
D = 0		Pneumon	ia					i	1 Week	
death certificate be executed e attending physician and of for use as the burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Last	c	or es e consequer or es a consequer							
d for d for	Part II. Other significant conditions co	ntabuting to death but not re-	tulting in the unde	rhving cause di	ven in Pert I	23h Did i	obacco use co	untribute to	the cause of death	
d by the setache	Tark in Other Significant Contantons Co	THIRDWING TO GOGIT DUTING TO	oning in the unce	mying cause gi	VOIT HIT OIL I.				bably 4∭ Unknow	
aw requii							performed? avsilable		ere autopsy findings silable prior to mpletion of cause death?	
ate ha						101	res 2 No	10	☐Yes 2☐ No	
certificate rector, pag	25. Was case referred to medical exeminer?				26. Place of D	eeth (Check only o	ne)			
- Z 20 Z	1 ☐ Yes 2 No	44 1	ER/Outpatient	3□ DOA Ot	her: 4 Nursing	Home 5 Resid	lence 6 Ott	ner (Specif	(y	
B et o	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Dete of tnjury (Month, Dey Year)	ry et rk?] Yes 2 ☐ No	28d. Describe t	28d. Describe how injury occurred					
To the Hospital or Attending P within 24 hours sher death to the Furneral Director. After toomplately filled in by the funer. Medical Certification:	3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)									
Hospit 4 hours Funer tely fill	29a. Certifier (Check only one) 1 Certifying Phy	rsician: To the best of my knot iner: On the basis of examina and manner stated.	owledge, death or ation end/or Invest	courred et the ti tigation, in my	me, date end plac opinion, deeth occ	ce, end due to the curred et the time,	cause(s) and m date end place,	anner as si and due to	ated. the cause(s)	
To the To the comple	29b. Signeture end title of certifier	242	Harris	29c. Licen			29d. Date signe	ed (Month,	Day, Year)	
17011	ANother	- IND		D00.	53615		Februar	cy 24	, 2000	
	30. Name and address of person who co	1	m 23a) (Type, Pri	n Ho	spital	, Beth	esola		1	
State	31. Dete filed (Month, Dey, Year)	32. Registrar's Sign	eture 4	land	,					



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

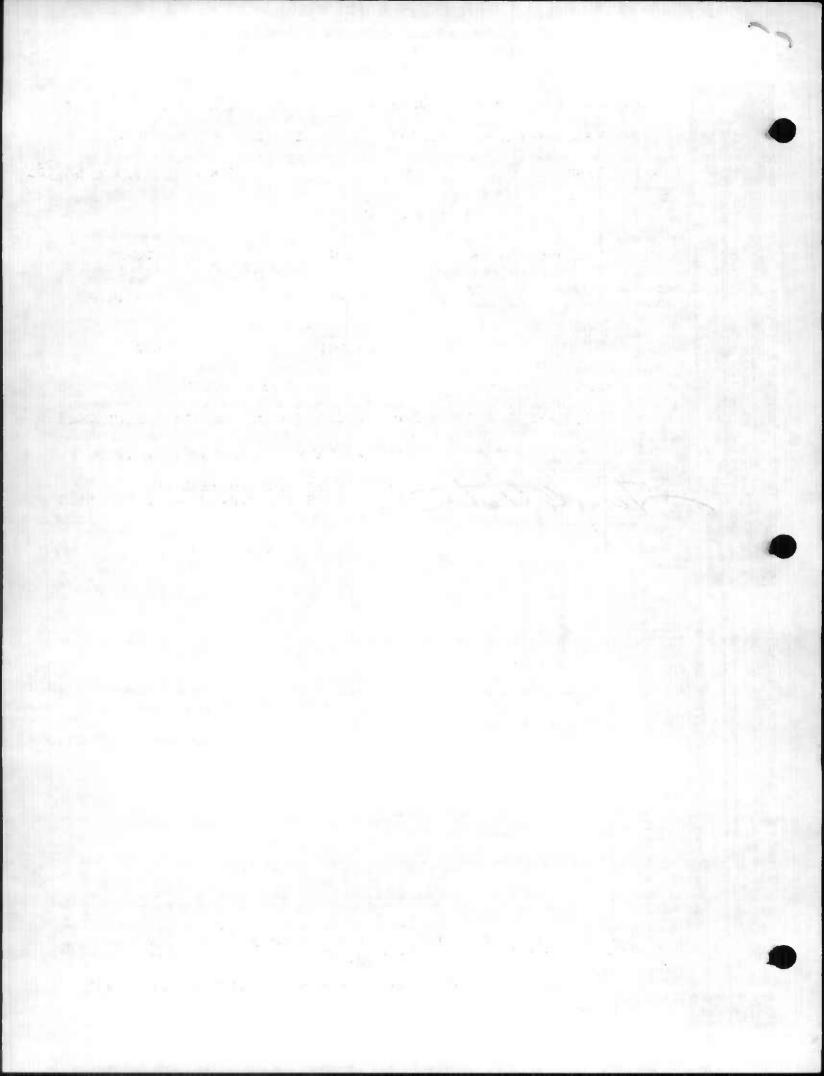
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					OGI	uncate	UI	Dealli			Reg. No.			
	Physician /Medical	Decedant's Nama (First, Middla, I SEVELLE	ast) MA	ΑE	SUMME	RS				2. Data of Do Month FEB.	24,200	Yaar	3. Tima of Death 1:50 PM	
	Examiner	4a Facility Nama (If not Institution, g BRADFORD O			ENTER				own, or Lo	ocation of Dear		of Deet	1	
	Funeral Director	5. Social Sacurity Number 6. 225-10-1139D	Sax 1 □ M 2 X F	7. Aga (In yrs. 88	last birthday) Yrs.	If Undar 1 Months		if Under Hours	24 Hrs. Min.	8. Data of Bi (Month, Di MARC	rth ay, Year) H 15,1	9. Birthplace (State or F. Country) NORTI		
	73	Usual Rasidance of Decedant												
	ath with the Marylenc 23a or 28a-1 show could be read or rai Director	10a, Stata 10b, County 10c, City, Town or Location P.G. BRANDYWINE											10d. Insida City Limits 1 Yas 2 □ No	
	188 Tec	10e. Street and Number				10f. Zip C	oda				10g. Citizen of	What Co	untry?	
	ath with	9401 CHELTEN										SA	dan tadin	
020	72 hours effer death with the Maryland natural; or items 23s or 28s4 show lites Examined must be notified a steel by Furneral Director	11. Marital Status 1 Navar Marriad 2 Married 3 Widowed 4 Divorced	Armed Fo	2 [XNo		Yas Deceda I Yas, specif		Specify.		ecify Yas or No Rican, atc.)		ack, White	- Amarican Indian, c, Whita, atc. BLACK	
ö	tura	15. Decedant's	Education		16a. Daced	lant's Usual	Occup	ation			16b. Kind of 8	Businass/	industry	
21215-0020	ed within 72 hours e ygiene. Nor than "natural", c	(Specify only highast (Secondary (0-12) 7 TH	rada completad) Collega (1	I-4or 5+)		kind of work DO NOT usa IOUSE			st of work	ing	N/	A		
	Hygie Hygie Co	17. Fathar's Nama (First, Middla, Las	0(1)					18 Moth	ar's Nam	a /First Middle	n, Maidan Suma			
Maryland	should be fill marked oth marked oth amatic even	WILLIAM S						16, 1410(11)		A FOU		,,,,,		
-	alth end 27 is mer traum	19a. Informant's Name/Ralationship RITA SUMMERS	(Typa, Print) S-PAGE	(daugh	19b. Mallir t e9)401	ng Addrass (Street LTE	and Numb	er or Run IDR	al Route Number BRA	nDYWIN	E, MD	(ip Gode) 0.20613	
Baltimore	Pages 1 ent of He nt: If Item iry or othe	20a. Mathod of Disposition 1 Burial 2 Cramation 3 4 Donation 5 Othar (Special Control of Control		Stata CI	Place of Dispo camatary, cren LIFTON	sition (Name natory or oth I CEM	a of par plac ETE	ca) ERY	3/	Data 4/200	20c. Location 0 VIR	- City or		
Balti	pemit. Pag Department Important: I any Injury o	21. Signature of Funaral Sarvice Lic		1	P		N F	ROYS	TER .		AL HOM		20033	
_	-	Yerry 9	V. alle	aher							ASH, D	.C.	20011	
	Physician /Medical Examiner	23a. Part 1. Enter the disasse, or construct, or heart talline. List on Immadiate Ceusa (Final disassa or condition	npications that cly ona causa on a	ausad ma daam ach lina.	Line	ar ma moda	orayı	lue	Lardiac	Las	vsc		Approximete Intarval Between Onsat and Death	
	ě	resulting in daeth)	9	4 /00 10 10	Prou	unice of)	7	Lun	rox			100 100 100	6 horle	
90,	certificate be executed ding physicien and ise as the buriel-fransit	Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Couse (Disease or injury that initiated avants	c	Dua to (o	or es a conseq	uence (f):						1		
x 68760,	5 00	that initiated avants resulting in death) Last		Due to (o	r as a consaq	uence of):								
Вох		Bridge March	u									i		
P.O.	thet the death led by the etter deteched for y Physicia	Part II. Other significant conditions	contributing to de	eath but not ras	ulting in tha u	ndarlying car	usa giv	van in Part	1.		Yes 2 Tho		to the cause of death	
	igned be de							-						
Records,	been should should									24a. Wa	s an autopsy formad?		Ware autopsy findings available prior to completion of cause of death?	
al Re	The page									10	Yas 2000		1 ☐ Yas 2 ☐ No	
Vital	Physician: The this certificate rat director, part of the Co	25. Wes case rafarred to medicat axaminer?					- 1 - 2 -		e of Deel	th (Check only	ona)			
of	To To	1 Yas 2 No	Hospital:	Inpatiant 2	ER/Outpatier	1 3 DO	Oth	har: 4 DN	ursing Ho	oma 5 🗆 Ras	sidanca 6 🗆 O	thar (Spe	cify)	
ion o	Attending Ph or death. ector: After th by the funeral	27. Manner of Death 1 Natural 5 Panding 2 Accident invastigat		of Injury th, Day Year)	28b. Tima of injury	M 28	c. Injui Wor	ryat rk? ∣Yas 2 ⊑] No	28d. Dascribe	how injury occi	urred		
Division	tal or Attending P rs after death. at Director: After t led in by the funers Certification:	2 Account									Number or Rural Route Number,			
	To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Medical Certi		Physician: To the aminer: On tha be and man											
	To the within To the comple	29b. Signatura and titla of certifiar) 11	A - A	M	- 296	Licans	sa number	~~	1	29d. Data sign	ned (Mont	h, Day, Year)	
1		30. Nama and addrass of person wh	o completed cour	D M	n 23a) (Type	Print)-	-24	つつ		6.	29.	2000	
		LAXMI BEI					NCH	AVE	E.,C	LINTO	N, MD.	207	35	

DHMH 16 Rav 6/95

State • Registrar 31. Data filad (Month, Day, Yaar) MAR 0 2 2000

32. Ragistrar's Signatura



Amended Item #26, per MEO & G.P. at DVR, 2/28/00, Carroll County, wjl Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician	
/Medical	-
Examiner	4

3. Tima of Death 0210 AM

10d. Inside City Limits

Approximate Intervel Between Onset and Death

29d. Date signed (Month, Day, Year)

FEB. 20, 2000

1 ☐ Yes 2 No

Funeral

Director

r than "natural", or items 23s or 28s-f show the Hedical Examiner must be natified at filed within 72 hours after I Hygiene. permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygieru Important: If fem 27 le marked other than any Injury or other traumatic avant, the inges.

Baltimore, Maryland 21215-0020

Physician /Medical **Examiner**

physician and s the burial-transit The law requires that the death certificate be executed Records, P.O. Box 68760 been signed be should be detr Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Diractor: After this certifica completely filled in by the funeral director,

CHRISTOPHER R. STUNTZ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 20, 2000 CHRISTOPHER RAY STUNTZ FEB. la Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 16181 OLD FREDERICK ROAD-B MT.AIRY HOWARD If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 1977 Maryland 5. Sociel Security Number 7. Age (In yrs. last birthday) Months Hours 11€M 2□ F 22 Yrs 213-19-3149 Usuel Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location MD **HOWARD** MT. AIRY Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 16361 OLD FREDERICK ROAD 21771 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No f Yes, Give 1 ☐ Yes 2X No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Year or Dates Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) CONSTRUCTION LABORER CONSTRUCTION 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be RAY S. STUNTZ JANYCE ANITA LUMSDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR. & MRS. RAY STUNTZ (Parents) 16361 OLD FREDERICK ROAD MT. AIRY, MD 21771 20b. Place of Disposition (Name of 20e. Method of Disposition 20c. Location - City or Town, State MT. VIEW CEMETERY Burial 2 Cremation 3 Removal from State 2/24/2000 MARRIOTTSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signaturu of Funeral Service License 22. Name and Address of Facility
HAIGHT FUNERAL HOME & CHAPEL (Box 195) taight SYKESVILLE, MD 21784 (410)-795-1400 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final diseasa or condition resulting in deeth) Due to (or as a consequence of): Sequentielly list conditions.

Due to (c	or as a consequence of	ŋ:				
tributing to death but not res	ulting in the underlying	g ceuse given in Part I.	23b. Did tobacco use co	ntribute to the cause of death		
			24a. Wes an autopsy performed?	24b. Were autopsy findings eveilable prior to completion of cause of death? 1 Yes 2 □ No		
		26. Place of 6	Deeth (Check only one)			
lospital: 1 Inpatient 2	ER/Outpatient 3			ner (Specify) (Scene)		
28a. Dete of Injury (Month, Day Year) 2/20/00	28b. Time of Injury 12:35 A M	28c. Injury at Work?	28d. Describe how injury occur SUBJECT SHOT S			
			281. Location (Street and Number or Rural Route Number, Rd. City or Town, State) 16181 Old Frederick Rd.			
	ospital: 1 Inpatient 2 28a. Dete of Injury (Month, Day Year) 28e. Place of Injury - At h	ospital: 1 Inpatient 2 ER/Outpatient 3 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 12 i 35 A M 28e. Place of Injury. At home, farm, street, fact	Ospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursin 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 2 28c. Injury at Work? 1 Yes 28 No 28e. Place of Injury - At home, farm, street, factory, office	tributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use con the property of the pr		

29c. License number

O.C.M.E

111 Penn Street, Baltimore, Maryland 21201

State Registrar 29b. Signature and title of certifier

31. Dete filed (Month, Day, Year)

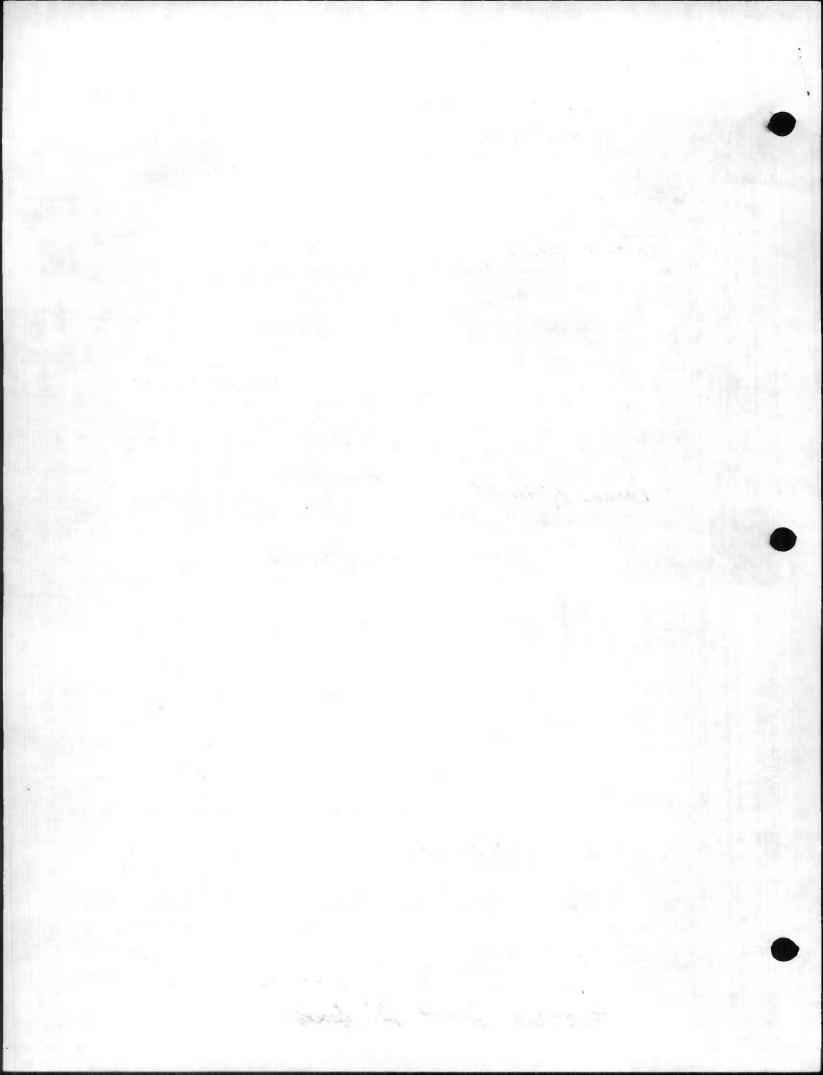
JACK M. TIMS.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 2 8 2000

M.D

32. Registrar's Signature



Please			Departm	ble Ink. Assure ent of Health an		-	0 08554		
			Certific	ate of Death		Reg. No.			
1. Decedent's Name (First, Middle, L			,	2	2. Dete of Month		3. Time of Death		
Elizabet	h	S	TAU:	В	Febru		3:20am		
4e. Fecility Neme (If not institution, ga	ve street end number)			4b. City, Town	or Location of De				
Westminster 1	Vursing an	d Conver	lescent	Center West	minster	CAN	LECLL		
	Sex 7. Age	(In yrs. last bii	thday) If Ur Yrs. Mont	nder 1 Year If Under 24 ths Deys Hours	Vin. (Month,	Birth Day, Year)	Birthpiece (State or Foreign Country)		
Jsuel Residence of Decedent		70			pec./	,1903	Germany		
10e. State 10b. County		10c. City, Tow	n or Location	-			10d. Inside City Limits		
Maryland Car	roll	West	minst	er			1 ☐ Yes 🌿 😾 No		
0e. Street end Number				Zip Code		10g. Citizen of WI	het Country?		
720 7 - 1 - 1	01	- 3					States		
738 Leisters 1. Meritel Status	12. Was Decedent E		13 Was De	21157 ecedent of Hispenic Origin	/Conside Vac as		- American Indien,		
1 Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N		If Yes,	specify Cuben, Mexican, P	uerto Rican, etc.)		, White, etc.		
3 ₩ Widowed 4 □ Divorced	If Yes, Give Yeer or Detes:	0	1□ Ye	s 2 No Specify:		Specify:	White		
15. Decedent's E		160	Decedent's I	Jsuel Occupation		16h Kind of Bu-	ino se/lodustry		
(Specify only highest gr	ade completed)		(Give kind of	work done during most of Tuse retired)	working	16b. Kind of Bus	iness/industry		
Elementery/Secondery (0-12)	College (1-4or 5-	+)		amstress		Cloth	ina		
7. Father's Neme (First, Middle, Las	t)		26		Name (First Mide	fle, Maiden Sumame			
						,			
Johan 9e. Informent's Neme/Rejetionship	Landowsk		Mailina Add	Anna ress (Street and Number of	e Dural Davida Min	abor Cibro Tono	Note Tie Code!		
Adolf Staub/st	cepson	67	09 So	uth West (nurai Houte Nun	Rd. 341^{T}	renton, Fla. 32693		
De. Method of Disposition			Disposition (
1 XBuriel 2 Cremetion 3	Removel from State	cemeter	y, crematory	or other place)	Date		ity or Town, Stete		
4 □ Donetion 5 □ Other (Speci	fy)	Garde	ns of	Faith 2/	28/00	Baltimo	re, MD		
1. Signeture of Funerel Service Lice	nsee			end Address of Fecility	91	Willis	Street		
Maket 1	7. Mhe	13-	Myer	s Funeral	Home We	estminst	er, MD 21157		
23a. Pert1. Enter the disease, or con shock, or heert feilure. List only	plicetions thet caused t	the deeth. Do r					Approximete		
shock, or neer renure. List only	one ceuse on each line	9.					Intervei Between Onset end Death		
mmediete Ceuse (Finel	O docho	mei	1				011		
esulting in death)	· Congre		Heimen'r	-0			de		
	100	oue to (or as a	consequence	or):			7.5		
	p. 47 C	V 12		- 0			24		
equentielly list conditions, eny, leading to immediate ause. Enter Underlying		ue to (or es e	consequence	Of):					
euse (Diseese or injury net initieted events	c						1		
esuiting In deeth) Lest	D	ue to (or es e c	onsequence	of):					
	d						i		
							4		
ert II. Other significant conditions	contributing to death but	not resulting in	the underlyln	ig ceuse given in Pert I.	23b. Di	d tobacco use contr	ributa to the causa of death?		
					1[Yas 2 KNo 3	B Probably 4 Unknown		
					24e. We	es en eutopsy riormed?	24b. Were autopsy findings sveilable prior to		
			-		-		completion of ceuse of deeth?		
					10	Yes 2 No	1 Yes 2 No		
. Wes case referred to medical				26. Piace of	Deeth (Check only				
exeminer? 1 Yes 2 No	Hospital:	t 2 ER/Ou	tpetient 3	Other:			(Specify)		
. Menner of Deeth	28e. Dete of Injury	28b. T	ime of	28c. Injury et		Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how Injury occurred			
1 Netural 5 ☐ Pending investigatio	(Month, Day		njury M	Work? 1 ☐ Yes 2 ☐ No					
3 ☐ Suicide 6 ☐ Could not b	e One Disease laive	v - At home fe			28f. Location	(Street and Number	or Rural Route Number,		
4 ☐ Homicide determined	building, etc.	(Specify)	, 5.1001, 100	,, 91100		own, State)			
9a. Certifier 1 Certifying Ph	welclen. To the best of	mu kmandada -	death	and set the time.	1				
Joiling II a Contiving Pr	yalciani. To the Dest of	my knowledge,	deeth occurr	ed et the time, dete end pi	ece, end due to th	e ceuse(s) end menr	ner es steted.		
2 Madical Exal	niner: On the basis of e	d annihite trott ent	not investiget	ion, in my opinion, death o	ccurred et the time	e, date and piece, en	d due to the cause(s)		
(Check only 2 Madical Exer	end menner stete	ed.		29c. License number	ccurred et the time	e, date and piece, en			

Physician /Medical **Examiner** To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and complately filled in by the funeral director, page 2 should be deteched for use as the bunal-transit Division of Vital Records, P.O. Box 68760,

Registrar

31. Date filed (Month, Day, Year)

FEB 2 8 2000

30. Nauma

Physician

/Medical

Examiner

Director

Be Completed by Funeral

2

Physician/Medical Examiner

by

Completed

Be

Medical Certification: To

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Depertment of Health and Mental hygiena. Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinal must be notified at

Baltimore, Maryland 21215-0020

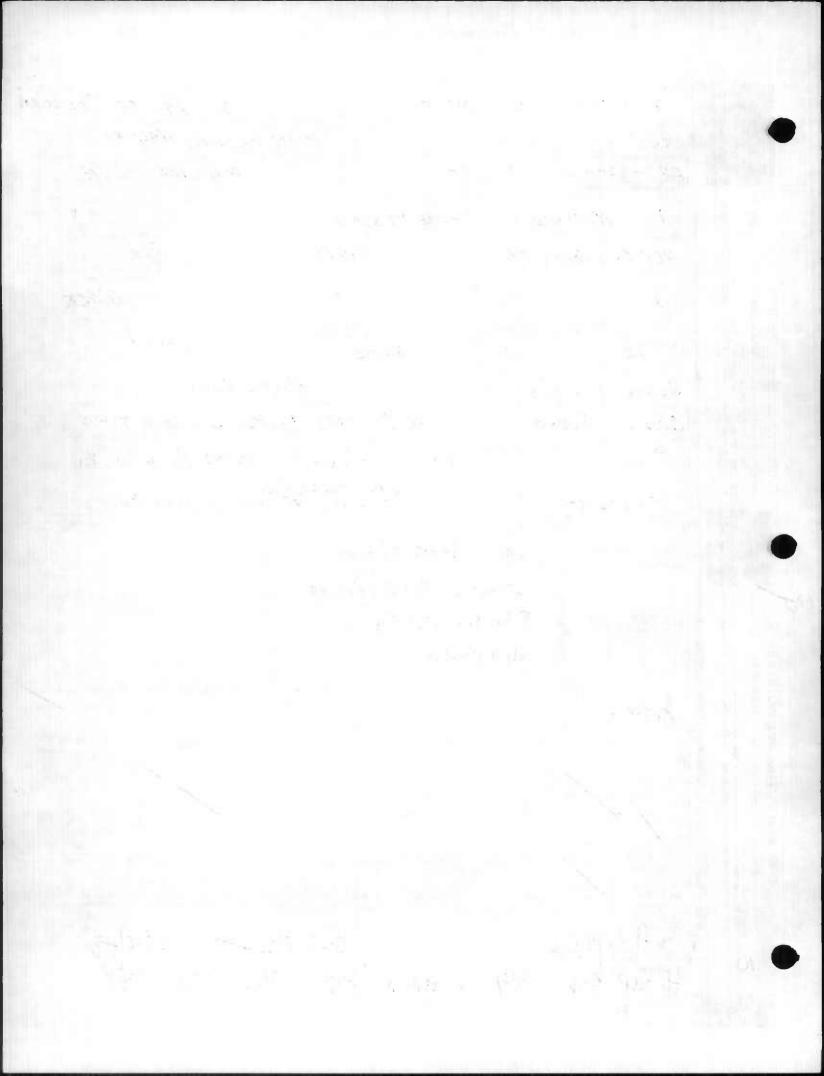
ELIZABETH STAUB



Gelmmiddet 2 1200 - DIFFE 2 1200 - PART PART ON SUBT

		State	e of Maryland	Department of Certificate			giene 🛭 🗍	09555
	Physician /Medical	1. Decedent's Name (First, Middle, Last) THELMA I.	5MiTH	1		2. Dete of Dee Month	th Day Year 23 00	3. Time of Death
	Examiner Funeral Director	4a Facility Nama (If not Institution, give street english of the first part of the facility Number 6. Sex 1 M 2 M 2 M	3 f. 7. Age (In yrs. last	birthday) if Under 1 Ye Yrs. Months Da	ear If Under 24 Hrs.	E GRAC	9. Bir	
		Usuel Residence of Decedent 10a. State 10b. County		own or Location		Tring of	,//~	10d. insida City Limits 1-d Yas 2 □ No
	iter death with the Marylen ritems 23s or 23s-4 show ying must be notified at Funeral Director	MD HARFORD 10e. Street and Number 905 Elizabeth 5+		E DE GRACE 104. Zip Cod 2104	ie		10g. Citizen of Whet Co	(
020	It, or items Its charter by Fune	11. Marital Stetus 1 Nevar Marriad 2 Married 1 Nevar Marriad 2 Married 1 Yes	Decedent Evar in U,S. of Forcas? fas 2 2 No s, Give or Detas:		of Hispenic Origin? (S Cuban, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Bleck, Whit Specify: [3]	te, etc.
21215-0020	c - 2 -	15. Decedent's Education (Specify only highest greda compla Elementery/Secondery (0-12) Colle	ted) ge (1-4or 5+)	6e. Decedent's Usuel Oc (Give kind of work do life. DO NOT use re NURSE	cupation ina during most of wor tired)	king	16b. Kind of Buainess	Andustry
Maryland		17. Fether's Neme (First, Middle, Last) Geolge W. Davi's 19a. Informent's Neme/Reletionship (Type, Print)		19b. Mailing Address <i>(Str</i>	MINNS	e GUNA		Zin Code)
84	Pages 1 and 2 should sent of Health end Mer nt: if item 27 is marke iry or other traumatic	Charlene BODNE 20a. Method of Disposition 1 Buriai 2 Cremetion 3 Removel f	20b. Piece	PO BOX 49: a of Disposition (Neme of etery, cremetory or other	59 Chatt	Dete Dete	TENN. 37 20c. Location - City or	405
Baltimore	permit. Page Department of Important: If any injury or office.	4 □ Donetion 5 □ Other (Specify) 21. Signeture of Funerei Servica Licensee Riag Scatt	ARlin	22. Name end Ad BEARD CO	Idress of Facility	3-6-00	HRHNgton	, Va.
Jh.	Physician /Medical Examiner	23e. Pert1. Enter the disease, or complications to shock, or heart feilure. List only one ceuse Immediate Ceuse (Final disease or condition resulting in deeth)	PANIC PAN Due to (or as MCC)		dying, such es cardiad	c or respiratory er	rest,	Approximete Interval Between Onset and Deeth
Box 68760,	at the death certificate be executed the transmit state of the strength of the	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in deeth) Lest	Phopus M	s e consequence of):	/1 /0			
O. 9	d by the etache	Pert II. Other significant conditions contributing	to death but not resultin	ng in tha undariying cause	given in Pert I.			a to the cause of death?
Records,	2 0 C					perfor	med?	Wera eutopsy findings sveilable prior to completion of cause of deeth?
on of Vital F	hysician: his certification of director To Be	27. Manner of Death 1 Of Natural 5 ☐ Pending 28a. [26. Plece of Dec Other: 4 Nursing F njury et Work? 1 Yes 2 No	eth (Check only)	res 2 ☑ No Ne) lence 6 ☐ Other (Speciow Injury occurred	1 Yes 2 No
Division	tal or Attending P rs efter death. al Director: After t led in by the funera Certification:	investigation Could not be determined 28e. [Plece of Injury - At home puilding, etc. (Specify)	a, farm, street, factory, off		28f. Location (5 City or Ton	Street and Number or F rn, State)	lural Routa Number,
	the Hospit thin 24 hour the Funers mpletely fills Medical (A CONTRACTOR OF THE CONTRACTOR	o the best of my knowled he basis of examination mannar stated.	end/or investigation, in n	e time, dete end plece ny opinion, deeth occu	irred et the time, o	ceuse(s) end manner a date end piece, and du 29d. Date signed (Mon	e to the ceuse(s)
	10	29b. Signature and title of number 30. Name and eddress of person who completed	cause of death (Item 22	D	464/2	_	2/45/	7
	State Registrar	HI SUP SIM 3/	2 S W	ncon by	es Ma	6 M	n 457	1

State Registrar



		State of M	arylan	-	artmen rtificat			ind M	lental Hy	rgiene	0	08556
	1. Decedent's Name (First, Middle, Last)							2. Date of De Month	eath Day	Year	3. Time of Death
Physician /Medical	CARL RAYMOND SM	HTIN							March			11:07 pm
Examiner	4a Facility Name (If not institution, give	street and number)		ar.		4	lb. City, To	wn, or Lo	cation of Deat	h 4c. County	of Death	
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Funeral Director	215-14-6227	X 7. A⊊ ŠM 2□ F	78	ast birthday) Yrs.	Months	1 Year Days	If Under a	Min.	8. Date of Bi (Month, Di MAY	7 1921	9. Birthi MARY	place (State or Foreign otn) LAND
death with the Maryland one 23e or 28e-f ahow count be notified at	Usual Residence of Decedent 10s. Stata 10b. County		10c. City	, Town or Lo								10d. Inside City Limits
vith the Ma tor 28e-f a be notified Director	MARYLAND ALLEGATION ALLEGATION AND ALLEGATION ALLEGATIO	ANY		CUMBI	ERLAN				1	10g. Citizen of V	Vhat Cou	ntrv?
Se or	467 GOETHE STREE	r				2150	2			U.S.A.		
ther death v	11. Marital Status	12. Was Decedent		S. 13.	Was Dece	dent of H	ispanic Orig	gin? (Spe	ecify Yes or No Rican, atc.)	- 14. Rac		can Indian,
by	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 X Yes 2 1 If Yes, Give Year or Dates:	N°942-	1946	il Yes, spe		Specify:	, Puerto	Pican, atc.)		k, White,	
72 ho	15. Decedent's Edu (Specify only highest grad	cation		16a. Dece	dent's Usua	al Occup	ation during most	of work	ina	16b. Kind of B	ısiness/în	dustry
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uld be the Mental H rked off the ever	17. Father's Name (First, Middle, Last) CLOYD SMITH								WAGNE	n, Maiden Surnam R	10)	
d d d	19a. Informant's Name/Relationship (7) MARCELLA L. SMITH		IFE							MARYLAN		
mil. Pages 1 an partment of Heal portant: if Nem 2 y Injury or other 28.	20a. Method of Disposition 1 Suriat 2 Cremation 3 4 Donation 5 Other (Specify)	Removal from State	CE	lace of Dispo ematary, cred	matory or o	ther plac	») TERY	MARC	Data :H 6 20	20c. Location -		STONE MD.
permit. Page Department of Important: If any injury or pnce.	21. Signature of Funeral Service Ligans	M in	1.00.	22	Name an MERRI	d Addre	S of Facility	FUNE	RAL HO	ME P.A.		
	Dale 2.	Herrica	d the death				CATUR STREET CUMBERLAND MARYLAND of dying, such as cardiac or respiratory arrast, Approximata					
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	seve	The state of the s	nronic		ruct	ive P	u1mc	onary D	isease		10 years
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2 22 0	Cause (Disease or injury that initiated events resulting in death) Last	d	Due to (or	as a conseq	juence of):							
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m	Part II. Other significant conditions con Conjestive He			iking in the u	nderlying o	ause giv	en in Part I.			Yes 2 No		to the cause of death?
requi									24a. Was	s an autopsy ormed?	av Ct	fera autopsy findings vailable prior to ompletion of cause death?
The last page 2									10	Yes 20 No		□Yes 2□No
certificate has birector, page 2 a	25. Was case referred to medicat						26 Place	of Deatl	Check only		1	
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ding Phys h. After this funeral di	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Data of Inju (Month, Da		28b. Time of thijury		8c. Injur Wor				how injury occur		,
r Atten rector: by the	3 Suicide 6 Could not be determined	28e. Place of In building, et	jury - At ho ic. (Specify	me, farm, str	reet, factor					(Street and Numb wn, State)	per or Rur	ral Route Number,
To the Hospital of within 24 hours at To the Funeral Discompletaly filled is Medical Cel	29a, Certifier 1 Certifying Physicians (Check only 2 March Exemicans)	sician: To the best ner: On the basis o and manner st	f examinati	vledge, death ion and/or in	n occurred vastigation	at the tin	ne, data and pinion, deal	d place, th occurr	and due to the ed at the time	cause(s) and ma , date and place,	anner as a	stated. to the cause(s)
of the complete of the complet	29b. Signature and title of conflict	C o mornor st	-124		29	. Licens	e number			29d. Date signe	d (Month,	Day, Year)
2	1	for/			1	Da	3280			March	١,	2000
d	30. Name and address of person who co	mpleted cause of o	ieath (Item	23a) (Tyne	Print)	ע 3	3200			rarcil	/	2000
nis	Dr. Sunil Gupta,					B1do	. Cum	ber1	and. M	D 21502		
State	31, Date filed (Month, Day, Year)	32 Registr										
Registrar	MAR 0 6 2000	De		NO ,	Spor	Kal						

DHMH 16 Rev 6/95

person is aposed

one to said

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Tima of Death Month **Physician** 3 JEAN CROSSER STEELE MARCH 2000 3:00 P.M. /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street end number) 4c. County of Death **Examiner** 7113 CHAMBERLAIN ROAD BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, JULY 22 5. Sociel Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours 1917 WEST VIRGINIA Yrs. Director 213 22 2988 Usuel Residence of Decedent 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes XX No Directo MARYLAND BALTIMORE BALTIMORE 288-1 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ò 21244 7113 CHAMBERLAIN ROAD U.S. Name 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2200 o If Yes, Give Yeer or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 Never Merried 2 Merried 8 altimore, Maryland 21215-0020 Specify: WHITE 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BEAUTY SHOP Elementery/Secondery (0-12) College (1-4or 5+) 10 HAIRDRESSER OWN BUSINESS 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be 8 and Mental ANNA GREEN JOSEPH H. MORTON To Pages 1 and 2 should 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) or other traus Health 7113 CHAMBERLAIN ROAD, BALTIMORE, MD 21244 IRENE SMITH / DAUGHTER 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stela ö 1 ABuriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 3/6/00 CUMBERLAND, MD SUNSET MEMORIAL PARK 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 PUC 23a. Pert1. Enter the disease, or complications that caused the deeth. shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Do not enter the mode of dying, such as cardiac or respiretory errest, **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examine Examiner physician and s the burial-transit be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Intury that initiated events resulting in death) Last Box 68760. Physician/Medical signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i P.O. 1 Yaa 2 No 3 Probably The lew requires that Records. P 24b. Were autopsy findings aveilable prior to 24a. Was an autopsy performed? Completed completion of cause of death? page 2 s 2 2 No 1 ☐ Yes 2 No 1 Yes Division of Vital or Attending Physician; 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of After 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigetion 2 Accident after deat Director: 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 5 4 Homicide • Funeral Di 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end placa, and due to the cause(s) and manner as stated.
2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) end menner stated. 29e. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier death (Item 23a) (Type, Print) werne and address of person who com 31. Dete filed (Month, Dey, Year) Registrer's Signeture MAR 0 6 2000 Registrar

DHMH 16 Ray 6/95

200 S U SAX

		State of Ma	ryland /				lealth a	ind N		giene) (3558		
	1. Decedent's Name (First, Middle, Las	st)							2. Date of Dec	ath		3. Time of Death		
Physician	RAYMOND ALFRED	CIDEC							Month	Day	Year	7.45 D W		
_/Medical	4a Facility Name (If not institution, give					1	lb. City. Toy	vn. or L	FEB ocation of Deeth		000 v of Deat	7:45 P.M.		
Examiner			HOME											
	FROSTBURG VILLA			hirthday	If Under 1	Yeer	FROST			ALLEC	-	polace (State or Englan		
Funeral	5. Social Security Number 6. S 216 20 2010	KIM 2 IF	(In yrs. last	Yrs.		Days	Hours	Min.	8. Date of Birt (Month, Da			nplece (State or Foreign untry)		
Director	Usual Residence of Decedent	/	3						JUNE 21	1926	MAR	YLAND		
and we	10a. State 10b. County		10c. City, To	own or Loca	ation			-				10d. Inside City Limits		
f sho	MARYLAND ALLEGAN	Y	FROST	BURG								1 Yes 2 □ No		
vith the Marylan s or 28a-f show be nouthed at	10e. Street and Number				10f. Zip C	ode				10g. Citizen of	What Co	untry?		
E ON D		TANE			1									
r Herr death w	100 HONEYSUCKLE	LANE 12. Was Decedent E	iver in II C	12 W	215		ienanio Orle	nin? /Cr	poity Vee or No	U.S.		rican Indien,		
Production of the state of the	11. Marital Status	Armed Forces?		If Y	13. Was Decedent of Hispanic Origin? If Yes, specify Cuben, Mexicen, Pu			, Puerto	Ricen, etc.)	BI	ack, White			
0 0 5	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give	WW II	10	☐Yes 25	No	Specify:			Spec	y: WH	ITE		
hour hour	Λ.	Year or Dates:	1							16b. Kind of I	Quelnace/	Industry		
n 72	15. Decedent's Ed (Specify only highest gra	de completed)	"	16a. Decedent's Usual Occupation (Give kind of work done during most of wo life. DO NOT use retired)					king	TOD. KING OF	0001110000	moderny		
ed within 72 ho ygiene. or than "natur. It, the Mr d call.	Elementary/Secondary (0-12)	College (1-4or 5-	+)							MEMED E	MDTO	VED		
be filed within 72 hours ital Hygiene. d other than 'natural', event, the M draff Eas Be Completed by	12 17. Fether's Name (First, Middle, Last)			NEVER EMPLOYED 18. Mother's Nam						NEVER E		IED		
	CHARLES SIRES			18. Mother's Name (First, Middle, Maiden Surname) ELIZABETH WITCHELL					,					
s marke s marke surnatic	19a. Informant's Name/Relationship (1	Tuna Print)	1	Oh Mailina	Addross /	Street			ral Route Numbe		State 2	7in Code)		
75.5	HARRIET MILLER /	*							MEYERS					
f Healt fem 2 other	,													
Pages natt of I mt: If its iry or o	20a. Wethod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Donation 5 Other (Specify) 20c. Location - City FROSTBURG MEMORIAL PARK 3:/2/00 FROSTBURG													
permit. Pages 1 a Department of Hei Important: If Item any injury or othe once.	4 Donation 5 Other (Specify		FROST						2/00	FROSTBU	IKG,	MD		
Depariment of the part of the	21. Signature of Funeral Service Licen	500							. P.A.					
20240	21. Signature of Funeral Service Licensee 22. Name end Address of Fecility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532													
	23a. Part 1. Enter the danger of com- shock, or heart failure.	The cause on each line	the death. D	Do not enter	the mode	of dyin	ng, such as	cerdiac	or respiratory a	rrest,		Approximate Interval Between		
Physician												Onset and Death		
/Medicai	immediate Ceuse (Final disease or condition	CARDIA. ACUTE	CA	1125	T	,	SII	VU	S AK	PRZ-5	7	< 38MIN 2 MONTH		
Examiner	resulting in death)	1	Due to (or as	e consequ	ence of):				-4.0			_		
n is d		ACUTE	my	OCAK	DIA	4	11	1 ft	ARC71	ON	3	2 MONTH		
be axecuted sician and burial-transit	Sequentially list conditions,		Due to (or as									0.6		
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death certificate to attanding physical of for usa as the to iclan/Medical	Toolsting in boarry 2001													
th ce r use		d												
sici	Part II. Other significant conditions of	ontributing to death but	t not resultin	g in the und	deriying cau	ise giv	en in Part I		23b. Dld	tobacco uae c	ontribute	to the cause of death?		
at the death certi d by the attanding etached for usa a Physician/M	COM1625	TIVE	HZAN	87	TIAL	· W	OF		10	Yas 2 No	3 P	robably 4 Dunknown		
The law requires that the death certificate ate has been signed by the attending physpage 2 should be detached for use as the Completed by Physician/Medic	CONGEST CHRANIC C		1,0131	-	10000	~ ~ ~ /	12				_			
ould bluc	CHRONIC (BSTRUCTO	UE	AGLO	DINAR	Y .	DISE	45	24a. Was	an autopsy	24b.	Were autopsy findings available prior to		
s be 2 she												completion of cause of death?		
The law requir sate has been s page 2 should Completed									10	Yes 20 No		1 ☐ Yes 2011No		
ifficat	25. Was cese referred to medical						26 Place	of Dec	th (Check only o	.,				
sicle s cert direct	examiner?	Hospital: 1 ☐ Inpatier	+ 2∏ CD	/Outpatient	3□ DOA	Oth			ome 5 Resi		ther (Sne	citu)		
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ding Afta fune fune	1 Naturel 5 Pending investigation	(Month, Day	Year)	Injury	м		k? Yes 2 🔲 ∣	No						
deal ctor: y the	3 Suicide 6 Could not be		ry - At home	, farm, stree							ber or Ri	ural Route Number,		
tal or Attending P is after death. al Director: After ted in by the funera Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)													
	29a. Certifier 12 Certifying Ph	ysician: To the best of	f my knowled	doe, death o	occurred at	the tir	ne, date en	d place	, and due to the	cause(s) and r	nanner as	stated.		
ne Hosp n 24 hou ne Funer plately fil		niner: On the basis of and manner stat	examination	and/or Inve	stigation, i	n my o	plnion, dea	th occu	rred at the time,	date and place	, and due	to the ceuse(s)		
Vithin To the comple	29b. Signature and title of certifier		/		29c.	Licens	e number			29d. Date sign	ned (Mont	h, Day, Year)		
F > F U		4.0			-		1 4 1							

2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANG-HYUN OH, M.D.,
31. Dete filed (Month, Day, Year)
MAR 0 1 2000 48 TARN TERRACE, FROSTBURG, MD 21532

State Registrar

nes



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

198 1 1991 James & Store

State of Maryland / Department of Health and Mental Hygiene

					C	ertificate of	Death	Reg	J. No.	08559
	Dhysici	an	1. Decedent's Name (First, Middle, Las		~ 1.1		Mary 1	2. Dete of Death Month	Dey Year	3. Time of Death
8	Physicia /Medic			W.	Sit	es		FEBRUAR	¥ 26, 2000	2105
)	Examin	er	4a Facility Name (If not institution, give Sacred Heart H				Cumberl	and		llegany
	Funeral Director				rs. last birthd 76 Yrs	Months Days		8. Date of Birth Apr 30	(**)1923 9. Birth	nplace (State or Foreign
	and F		Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town o	r Location				10d. Inside City Limits
	Many	tor	MD Alle	gany	C	resaptov	vn			1 Yes 2 No
	h with the 23e or 28	Funeral Director	10e. Street and Number 13139 Warrior	Avenue S.W		10f. Zip Code	21502	10	g. Citizen of What Cou USA	untry?
020	n 72 hours after death with the Maryland *nature!, or frome 23s or 28s-f show edical Examiner must be notified a	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in Apriled Forces? 11 Yes 2 No It Yes, Give Year or Dates:		3. Was Decedent of If Yes, specify Cu		pecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: wh:	e, etc.
2-0	natur desi	eted	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. De	ecedent's Usual Occu ive kind of work done e. DO NOT use retir	upation e during most of work	king	6b. Kind of Business/I	industry
21215-0020	within the page	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		ired fac			PG Indust	tries
	uld be filed Vental Hygi rrked other rtic event, ti	o Be C	17. Fether's Name (First, Middle, Last) Arthur Lee Sit	es			18. Mother's Nam Louise	v (Co.	aiden Sumame) llins)	
Maryland	2 sho	-	19a. Informant's Name/Relationship (7 Helen R. Sites	ype, Print)	198 1	ailing Address (Stree	et and Number or Ru Lor Ave	ral Route Number, SW; Cres	City or Town, State, Zaptown	MD 21502
ore,	permit. Pages 1 and Department of Health Important: If Nem 27 any Injury or other to once.		Wife 20a. Method of Disposition	20b	. Ptace of Di cemetery,	sposition (Name of crematory or other pl	ace)	Dete 2	Oc. Location - City or 1	Town, Stete
	permit. Pages Department of Important: If the any Injury or o		1 Surial 2 Cremation 3 4 Donation 5 Other (Specify	R	estla				LaVale, N	MD
Bal	permit. Per Department Important: any injury any injury and any injury any injury and any injury any injury and any injury any injury and any injury any any injury any any any any any any any any any an		21. Signature of Funeral Servica Licans	1 Mari	voll-		esiffune and, Ma		P.A. 21502	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the debte cause on each line.	ath. Do not	enter the mode of dy	ring, such as cardiac	or respiratory arres	st,	Approximete Interval Between Onset and Death
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	Examiner		disease or condition resulting in death)	a. Due to	(or as a cor	DW-RE asequence of): MOUNT	O 110A 1C	10/ 1/10	10031	1 Hour
	D #	iner		b. Acur	E 1	MOUNT	DIA 1	NEARC	non	1 Hour
o,	axacut an and riaf-tran	Exam	Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Due to	(or as a cor	sequenca of):				
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	anding use s	M/UE		d						
	the attandir the attandir thed for use	Physician/M	Part II. Other eignificant conditions co	entributing to death but not r	esulting in th	e underlying cause ç	jiven in Part I.	23b. Did tob	pacco usa contribute	to the cause of death?
0.								1 □ Ya	2 □N6 3 □ Pr	robebly 4 Unknown
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E	ysician: The lav is certificata has director, page 2	BeC	25. Was case referred to medicat		/		26. Place of Dea	th (Check only one		
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ב	ling P	ion:	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year,	285 Tim Inju	ry W	uryat ork? ⊒Yas 2 ⊒No	28d. Describe how	w injury occurred	
	or Attending I after death. Director: After I in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined		t home, farm			28f. Location (Stre City or Town,	eet and Number or Ru State)	ural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edicai Ce		relcian: To the best of my k iner: On the basis of exami and manner stated.						
	To the within To the comple	Mex	29b. Signature and title of certifier	PHOSICU	AN	29c. Lice	5084	11	d. Date signed (Month	h, Day, Year)
	n	3	30. Name and add on person who c	completed cause of death (I	tem 23a) (Ty	pe, Print)	9125170	DRIVE	Commen	CAND MO
	Star Registra	_	31. Date filed Month, Day, Year) FEB 2 8 2000	2. Registrar's Sig	natur	sports	1			4)

from the specialist

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			State of Maryla	nd / Depa			Mental Hyg	iene () ()	00560
	Physician /Medical	Decadant's Neme (First, Middle, La Evelyn	st) L.	Scar	pelli		2. Dete of Death Month Feb 2	Dev Year	3. Time of Death 10:17am
	Examiner	4a Facility Nema (If not institution, giver Allegany Count 5. Social Security Number 6. S	y Nursing H	ome	If Under 1 Yee	Cumberl			legany
	Funeral Director		□M 2√ F 7	2 Yrs.	Months Day	s Hours Mir		Year 1927	inthpleca (Steta or Foreign Country) MD 10d. Inside City Limits
	iter death with the Mark them 23a or 28a-1 or 18a-1 or 19a-1 or 19	MD Alle 10e. Street and Number 13313 Bristol	gany Drive SW	Cui	mberlar 10f. Zip Code			0g. Citizan of Whet C	1 Yes 2 No Country?
020	by	11. Marital Status 1 Never Married 2 Married Widowed 4 Divorced	12. Was Decedant Ever in I Armed Forces? 1		Wes Decedent of if Yas, specify Cu	Hispanic Origin? (ben, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Raca - Am Bleck, Wh	ite, etc.
Maryland 21215-0020	r than the Mo	15. Decedent's Et (Specify only highest grade) Elementary/Secondary (0-12)	ducation ide completed) Collega (1-4or 5+)	(Give	dent's Usuei Occ e kind of work don DO NOT use retii maker	e during most of wared)	orking	on Home	s/industry
yland	De fil	17. Fether's Neme (First, Middle, Last, Danforth Linab	urg			Velma	(Hiet	t)	
_	od 2 stranger trans	19e. Informent's Neme/Raletionship (William L Scar Son 20e. Method of Disposition	pelli	1331	3 Brist	ol Dr S	W; Cumbe	City or Town, State, rland, M	ID 21502
Baltimore	permit. Pages 1 an Department of Haal Important: if Item 2 any Injury or other ang.	20e. Method of Disposition 1 IX Buriel 2 Cramation 3 C 4 Donetion 5 Other (Specification 2) 21. Signature of Funaral Service Licer	Removel from State (y) Fa	irvie	scarper	stian Ce	m2/26/ eral Hom	Artemas, e P.A. 21502	
	Physician /Medical Examiner Examiner Example:	23a. Part1. Entar tha disease, or conshock, or heert feilure. List on immediata Ceuse (Final disease or condition rasulting in deeth)	· Carci	Or as a consa-	a 0)	ying, such es cardi	ac or respiretory arra	ast,	Approximate Intervel Between Onset end Deeth
Box 68760,	a price	Sequentially list conditions, if eny, leeding to immediate causa. Entar Undardying Cause (Disaasa or injury thet initieted events resulting in deeth) Last	c	or es a consec					
P.O.	that the death ned by the atte detached for y Physicia	Pert ii. Other significant conditions of McGasfass to L	ontributing to death but not so	L. L	underlying ceuse	given in Pert I.			ts to the cause of death? Probably 4 Unknown
Division of Vital Records,	yalcien: The law requires that the death certificate is certificate has been signed by the attending physidirector, page 2 should be detached for use as the To Be Completed by Physician/Medicin	hyperfension	, Ho D-	r.T.		0 3	24e. Wes e perform	ned?	. Were eutopsy findings aveilable prior to complation of cause of daeth?
Vital	Physicien: Tr this certificate ral director, pa	25. Was casa rafarred to medical exeminer?	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpetie	nt 3 DOA	Whore > /	eeth (Check only on		
ision of	To the Hospital or Attending Physwithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: To	27. Manner of Daeth 1 Neturel 5 Panding 2 Accidant investigation 3 Suicide 6 Could not b	28e. Dete of Injury (Month, Day Year)	28b. Time of Injury	of 28c. In W	jury at łork? □ Yas 2 □ No	28d. Dascribe ho	ow injury occurred	
Div	spital or A nours after neral Direc filled in bi	4 Homicida datamined 29a. Certifier Decertifying Ph	building, atc. (Specials)	cify)	th occurred at tha	tima, date end plea	City or Town	n, Stete) ausa(s) and mannar	es stetad.
	To the Hosp within 24 hou To the Funer completely fil	(Check only 2 Medical Example) 29b. Signature end title of certifier	niner: On the basis of examinend manner steted.	ation end/or in	nvastigation, in my	y opinion, deeth occurs number	curred at the tima, d	ata and pleca, end do 9d. Date signed (Mo	ua to the ceuse(s)
	ms	30. Neme and eddress of person who V.A. Ranjith				. Cumbe	rland M)	
	State Registrar	31. Dete filed (Month, Dey, Year) FEB 2 5 200	32. Registrer's Sign	neture &	por	W			

Registrar

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4. December 10 November 100 And 100 An	-4		Cen	tificate	of L	Death	2. Date of D	Reg. N	lo.	-4.6	3. Time of Death
Decedent's Name (First, Middle, Las							Month	D	ay	Year	
VIVIAN ELIZABETH The Facility Name (If not institution, give					1 4	b. City, Town, or L	FEB ocation of Dea	18 th 4	2000 lc. County		11:10 P.M.
						LaVALE			ALLE		
103 HAROLD STREET 5. Sociel Security Number 6. Se	ex 7. Age (In yrs. lest bi	irthdey)	If Under 1 Y	/ear	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	irth			lace (Stete or Foreign try)
217 09 6867	□м 2√Г 8(Yrs.	Months D	ays	riours Miri.	OCT 22				YLAND
Usual Residence of Decedent 10a. State 10b. County	11	Oc. City, Tow	wn or Loc	eation						10	0d. Inside City Limits
											1 □ Yes ⊋ No
MARYLAND ALLEGANY 10e. Street and Number	(LaVAL	_E	10f. Zip Co	de			10g. C	Citizen of V	Vhaf Coun	1111
103 HAROLD STREE	ET				21	502		U.S.			
11. Marital Stetus	12. Was Decedent Eve Armed Forces?	er in U,S.	13. W	Vas Decedent	t of Hi	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or N	0-		e - Americ	
1 Never Married 2 Married	1 Yes 2X No			☐ Yes 2♥☐		Specify:	7 (10an, 010.)		Specify	TITT	ITE
3 ☐Widowed 4 ☐ Divorced	Year or Dates:						1.00				
15. Decedent's Ed (Specify only highest grad	de completed)	168	(Give k	ent's Usual O kind of work d OO NOT use ri	done d	furing most of worl	king	166.	Kind of Bu	isiness/inc	Justry
Elementery/Secondary (0-12)	College (1-4or 5+) 2			HOMEMAI					OWN HOME		
17. Father's Name (First, Middle, Last)			•			18. Mother's Nem	ne (First, Middle				
COBEY ENGLE						RUTH	WINEBE	RENN	ER		
19a. Informant's Name/Relationship (7									Stete, Zip	Code)	
DEBRA DEMPSEY / DA		OOb Bloom	103 HAROLD ST., LaVALE, MD 21502 (b) Place of Disposition (Name of Date 20c. Locat							Chu T-	we State
20a. Method of Disposition 1 Buriel 2 D Cremetion 3 D	Cremetion 3 Removal from State cemetery, cremetory or other piece)								n - City or Town, State		
4 □ Donation 5 □ Other (Specify 21 Signature of Funeral Service Licen	ination 5 ☐ Other (Specify) THE CUMBERLAND CREMATORY 2/20/00 CUMBER are of Funeral Sergice-Licensee 22. Name and Address of Facility								LIBEKI	LAND,	MD
23g Part 1 Enter the disease or come	too	a death. Do	SOV	WERS F	UNE IN	ERAL HOME	STBURG	, MD	2153	32	Annrovimete
23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in deeth)	one cause on each line. CARCI Du	NOMA (SOV 60 o not ente	WERS FI W. MA or the mode of	UNE IN	ERAL HOME	STBURG	MD errest,	2153		Approximete Interval Between Onset and Death 2 YEARS
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Registrar



DHMH 16 Rav 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

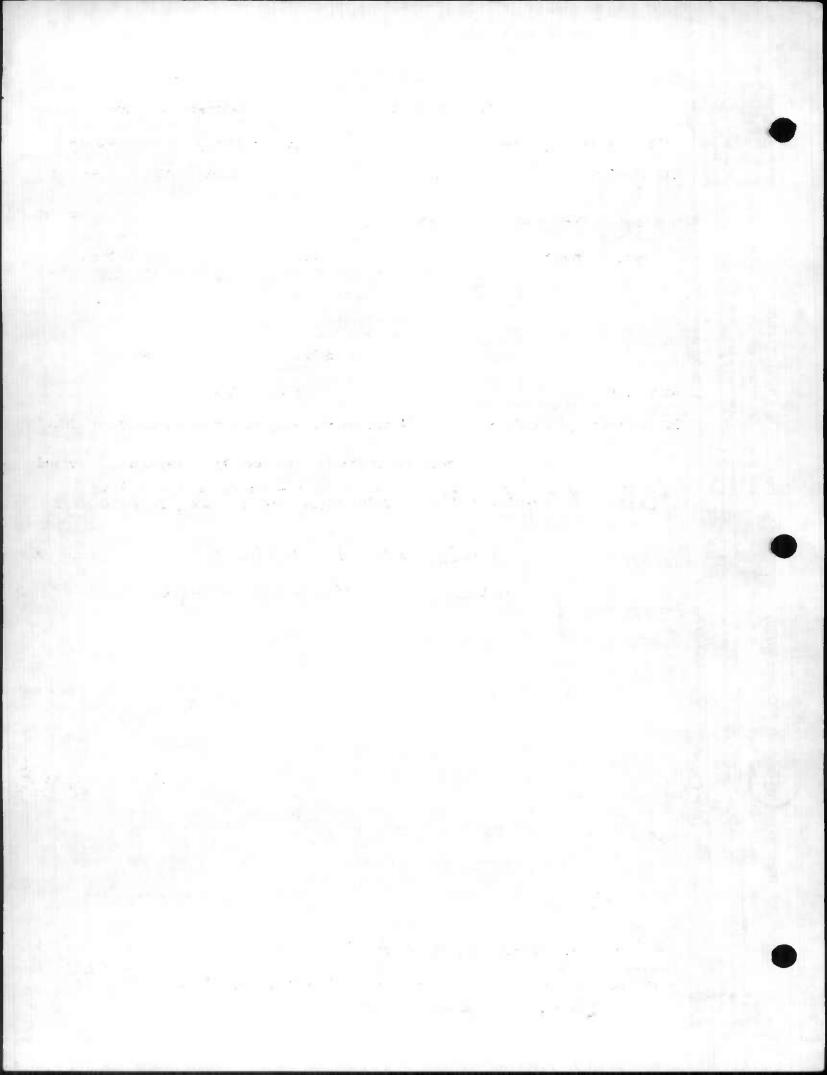
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

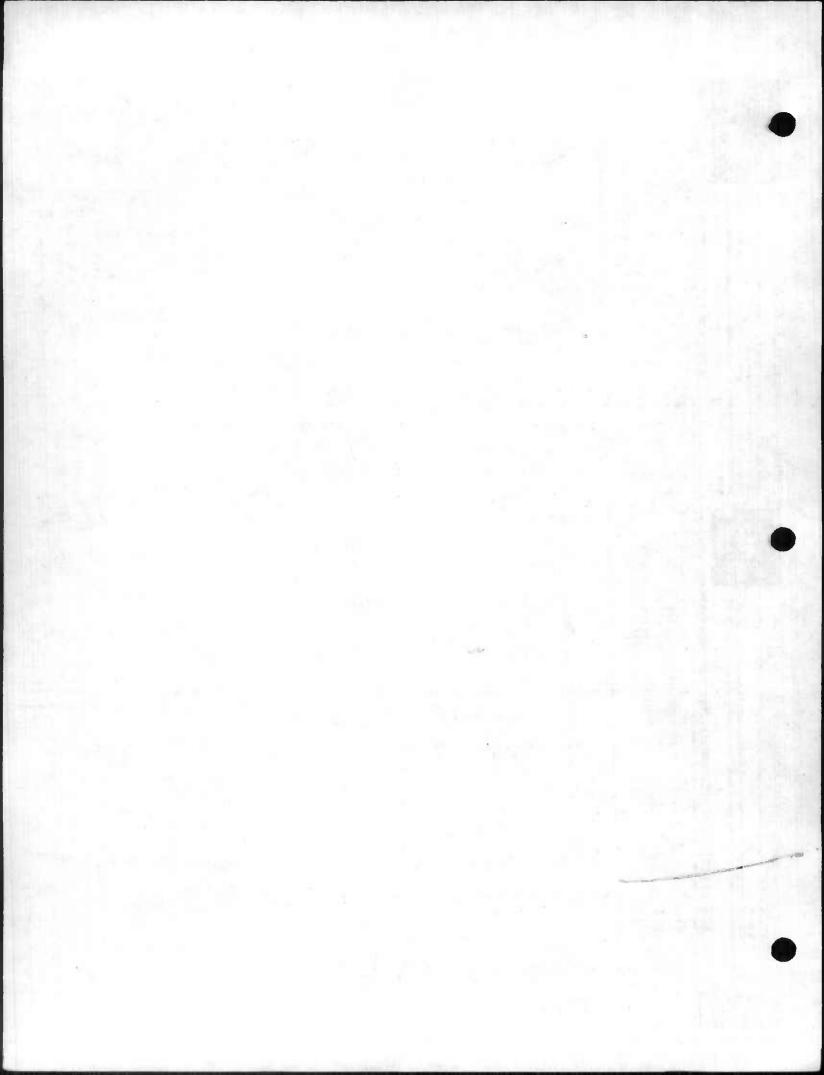
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Physician /Medical	1. Decedent's Name	e (First, Middle,		Nora Mae	Ship1	ey		2. Date of D Month Februa	Day	Year 000	3. Time of Deeth 2:30am
Examiner	4e Facility Neme (I	f not institution,	give street end nu	mber)			4b. City, Town, o			of Death	
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	Millenium 5. Sociel Security N		. Sex	7. Age (In yrs. la	et hirthday)	If Under 1 Yeer		r Spring		ntgom	
Funeral			1 M 2 XF		Yrs.	Months Deys		n. (Month, D	ey, Year)		ece (State or Foreign ry)
Director	212-78-13			87				March	7, 1912	Mar	yland
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deeth with the Maryland ms 23a or 28a-f show r.must be northed neral Director	3 7 7	roo. Oddiny								10	1⊠ Yes 2□ No
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72 hours efter deel natural, or items : sire! Examine! my sted by Funer	11, Walkar Status	od 000 ttomic	Armed Fo	orces?	f	Yes, specify Cut	Hispenic Origin? (ban, Mexican, Pue	nto Rican, etc.)	Blee	ck, White, e	otc.
0 1			If Yea, Gi	ve		☐Yes 2図No	Specify:		Specify	7. T.TL -2 -	
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d other than "natural swent, five Medical." Be Completed	(Spec	15. Decedent's	Education grade completed)		16e. Deced	ent's Usual Occu kind of work done	petion a during most of w ad)	orking	16b. Kind of B	usiness/Ind	ustry
than the Man	Elementery/Seco		College (life. L	OO NOT use retire	9d)				
vent, me	7					Homema	aker		Own	Home	
ent,	17. Father's Name	(First, Middle, La	ist)				18. Mother's N	eme (First, Middle	e, Malden Sumen	ne)	
<u>0</u>	D. 1. D.						***	n .			
To To					401 14-10	A 44 (C1	Virgie		has City as Tayon	Canto Tin	Codel
5	19a. Informent's Ne				190. Mailir	g Address (Stree	era Number or i	Hurai Houte Num	oer, City or Town,	Stete, Zip	Code)
other traumatic event, To Be C	Norita Si	hipley/	Daughter	r	114 F	lutton St	treet, G	aithersb	urg, Mar	yland	20877
the state of	20a. Method of Disp				aca of Dispo	sition (Neme of netory or other ple	ece)	Dete	20c. Location -	City or To	wn, State
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any mjury or				Bet			st Cemet	ery 3/1	Damasc	us, M	laryland
S	21. Signature of Fu	neral Service Lic	cansee			Name and Addr	Moleswor	th P. A.	Funeral	Home	
2 G	(Uli	- 1.	Woles	wath			dge Road				
	23a. Part1. Enter the shock, or hee	he disease, or co	omplications that	caused the death.	Do not ent	er the mode of dy	ing, auch as cardi	ec or respiretory	errest,	Tanu_	Approximate
	shock, or hee	rt failure. List or	nly one couse on e	each line.						i	Onset and Deeth
cian tical	Immediate Course (Tinel	^	4-	0			0			
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funeral director, page	1 Yes 2 ✓	No	Hospital:	Inpatient 2 🗆 E	R/Outpatien	t 3 DOA	ther: 4 Nursing	Home 5 Re	sidenca 6 □Oth	ner (Specify	1)
			28e. Date	of Injury oth, Day Year)	28b. Time of Injury	28c. fnju	ury at	28d. Describe	how Injury occur	rred	
tio of	1 Natural 2 Accident	5 Pending investiga		iai, boy 1001)	Hijoty]Yes 2□No				
completely filled in by the Medical Certifical	3 Suicide	6 ☐ Could no	t be 28e Place	a of Injury - At hor	ne farm str	eet factory office	9	28f. Location	(Street and Numi	ber or Rure	I Route Number.
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ğ	one)	2 Medical Ex		ner stated.	on and/or in	estigetion, in my	opinion, death oc	curred et the time	e, date and placa,	end due to	ine cause(s)
completely filled in by the Medical Certifical		title of certifier				29c. Licer	nse number		29d. Date signe	ed (Month, I	Dey, Year)
	11										
	mendurata mp 038262 te								tebru	ary	28,2000
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)									ele	
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Registrar		17 March 12 "	- 5000								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedant's Name (First, Middla, Last) 3. Time of Death Day Year Month Physician Feb. 22 2000 8:30pm Ruth Elizabeth Sheridan Standiford /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford If Under 1 Year If Under 24 Hrs. 8. Data of Birth
Months Davs Hours Min. (Month, Day, Year) Birthplaca (Stata or Foreign Country) 5. Social Sacurity Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2XF Months Yrs. 93 Director 220-22-0531 08/24/1906 Maryland Usual Rasidence of Decedent 10a State 10h County 10c. City, Town or Location 10d. fnside City Limits 1 Yes 2 □ No Harford Havre de Grace 10e Street and Number 10f Zin Code 10g. Citizan of What Country? 505 Congress Ave. Apt 407 21078 USA 12. Was Decedent Evar in U,S.
Armed Forces?
1 ☐ Yas 2 ☑ No
If Yas, Giva 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yas, specify Cuban, Mexican, Puano Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 X No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Pharmacy unknown Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be William P. Sheridan Sarah Briney 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Doris Deaner- Cousin 1304 C Scottsdale Dr., Bel Air, MD 21015 Barn 27 altimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) Data 20c. Location - City or Town, Stata 20a. Mathod of Disposition Pages 1 X Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) 2/26/00 Havre de Grace, MD Rock Run Cemetery 21. Signature of Funarai Sarvice Licensea 22. Nama and Addrass of Facility Mitchell-Smith Funeral Home, P.A. muth 123 S. Washington, Havre de Grace, MD 21078 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate tritarval Batween Onset and Death **Physician** Myocardial Injurct Subendocardial /Medical immediata Causa (Final disaasa or condition rasulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequance of): Physician/Medical Dua to (or as a consequence of): The law requires that the death certificate Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 □ Yee 2 No 3 Probably 4 Unknown Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes > No 1 Yes 2 No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was casa rafarred to medical examinar? 26. Placa of Death (Check only ona) Hospital: 1 → Inpatiant 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Yas 2 No Certification: To 28d. Describe how injury occurred 27. Mannar of Death 28b. Time of 28a. Data of Injury (Month, Day Year) 28c. injury at Work? 1 Natural
2 Accidant 5 Panding 1 Yas 2 No invastigation 6 Could not be datamined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office bullding, atc. (Specify) 4 Homicida 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar 29c. License number MIRRA A-BAGG 2.23.00 D43115 30. Nama and addgess of parson who complated causa of daath (Item 23a) (Type, Print) Hause De Groce, MD 21078 - Union Are, 31. Date filed (Month, Day, Year) 2 4 ZUUU 32. Registrar's Signature State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Deeth 3. Time of Death Day Year Month terman chweers Feb. 17 2000 1510 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Memorial Hospital Havre de Grace Harford If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Yrs. 63 07/01/1936 Maryland 215-32-1593 Usual Residence of Decedent 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Harford Havre de Grace 10e. Streat and Number 10f. Zip Code 10g. Citizen of What Country? 655 Otsego Street USA 21078 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, Whita, atc. 1 ☐ Yas 2 X No If Yas, Giva 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) 11th Truck Driver Freight Company 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surnama) William H. Schweers, Sr. Elsie Mae Walker 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary I. Schweers- Wife 655 Otsego St., Havre de Grace, MD 21078 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stete Burial 2 Cremation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Angel Hill Cemetery 2/22/00 Havre de Grace, MD 21. Signatura of Funaral Sarvice Licensea 22. Name and Addrass of Facility Mitchell-Smith Funeral Home, P.A. 123 S. Washington, Havre de Grace, 23a. Paft1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shoek, or heart failure. List only one cause on each line. MD 21078 Approximate tnterval Between Onset and Death VENTRICULAR Immediata Causa (Final MILAUTE disaasa or condition rasulting in death) PULMONAU Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Causa (Disease or Injury that initiated evants resulting In death) Last CARDIOGENIC MYOCARDIAL INFARCTION Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 19 No 1 □ Yas 2 □ No 26. Placa of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menne of Death 28a. Deta of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 5 Panding invastigation 2 Accident

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25. Was casa rafarred to medical axaminar?

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6 ☐ Could not be datamined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

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28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 11 Carllying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, data and place, and due to the cause(s) and menner steted.

296. Signature and title of certifig

29c. License number

29d. Data signed (Month, Day, Year) FEBRUARY 17, 2000

who completed causa of death (Item 23a) (Type, Print) WOHL

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State Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY P, 2000 **Physician** 0510 Melvin Thompson, Jr. /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4e Fecility Neme (If not Institution, give street and number) Examiner CHEVERLY PRINCE GEORGES GEORGES HOSPITAL CONTER PRINCE 8. Date of Birth (Month, Day, Year) May 12, 1947 If Under 24 Hrs. 5. Sociel Security Number 9. Birthplece (Steta or Foreign 6 Sev 7. Age (In yrs. lest birthdey) **Funeral** Deys 1 M 2 F Months Hours 251-80-0067 52 Yrs. Manning, SC **Director** Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-1 show Yes 2□ No DC none Washington, DC Director 10e. Street and Numbar 10f. Zip Code 10g. Citizen of Whet Country? 3046 North Street NW 20007 USA Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If Item 27 is marked other than "natural; or Items 23, ury or other traumatic event, in "leafer it Exprine mail". Funeral 12. Wes Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuben, Maxicen, Puerto Ricen, atc.) 14 Rece - American Indian Bleck, White, etc. XX Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes X No Specify: by Black 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) Maintenance Hospital 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Mariam Servance Melvin Thompson, Sr. 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Lottie Thompson - Sister 3303 11th Street NW Washington, DC 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Ramoval from Steta 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, Stata March Department of Important: If it sny injury or conce. Manning Cemetery Manning, SC 2000 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22 Name and Address of Fechieveneral Service, Inc. 5517 Vine Street Alexandria, VA 22310 the disease, or complications that ceused the deeth. Do not enter the mode of dying, such es cardlec or respiretory errest, or must failure. List only one ceuse on each line. Approximate Interval Batween Onset and Death **Physician** AKTERIOS CLEROTIC CARPIONASCULAR PISEASE Immediate Cause (Final disease or condition resulting in deeth) /iviedical Examiner Examiner physician and s the buriel-transit the death certificate be executed Sequentielly list conditions, if eny, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury that Initiated events resulting in deeth) Lest Due to (or es a consequence of): P.O. Box 68760. Physician/Medical Due to (or es a consequence of): ettending ph 23b. Did tobacco uea contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 3 □ Probably 4 Unknown 1 Yee 2 No signed t Division of Vital Records, ģ 24b. Were autopsy findings aveileble prior to 24e. Wes an autopsy performed? Completed completion of cause of death? aw i certificate hes b lirector, pege 2 s 1 Yes 2 No 1 □ Yes 2 □ No Attending Physician: Be 25. Was cese refarred to medical exeminer? 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 1 Inpatient 2 ER/Outpetient 3 DOA Certification: To this 27. Menner of Death 28a. Dete of Injury (Month, Dey Yeer) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Naturel 5 Pending 1 Yes 2 No 2 Accident Investigation efter deatl Director: 3 Sulcida 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide • Funeral Dire ò 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) and manner es stated. edicai To the Fune completely f (Check only one) 25 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and piece, and due to the cause(s) and manner stated. To the I within 2. 29d. Data signed (Month, Day, Year) 29c. Licanse number

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32. Registrar's Signeture

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State of Maryland / Department of Health and Mental Hygiene

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	1 Keels	et mo.		7	04	772 2		Februar	y 24,	2000
10	30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)									
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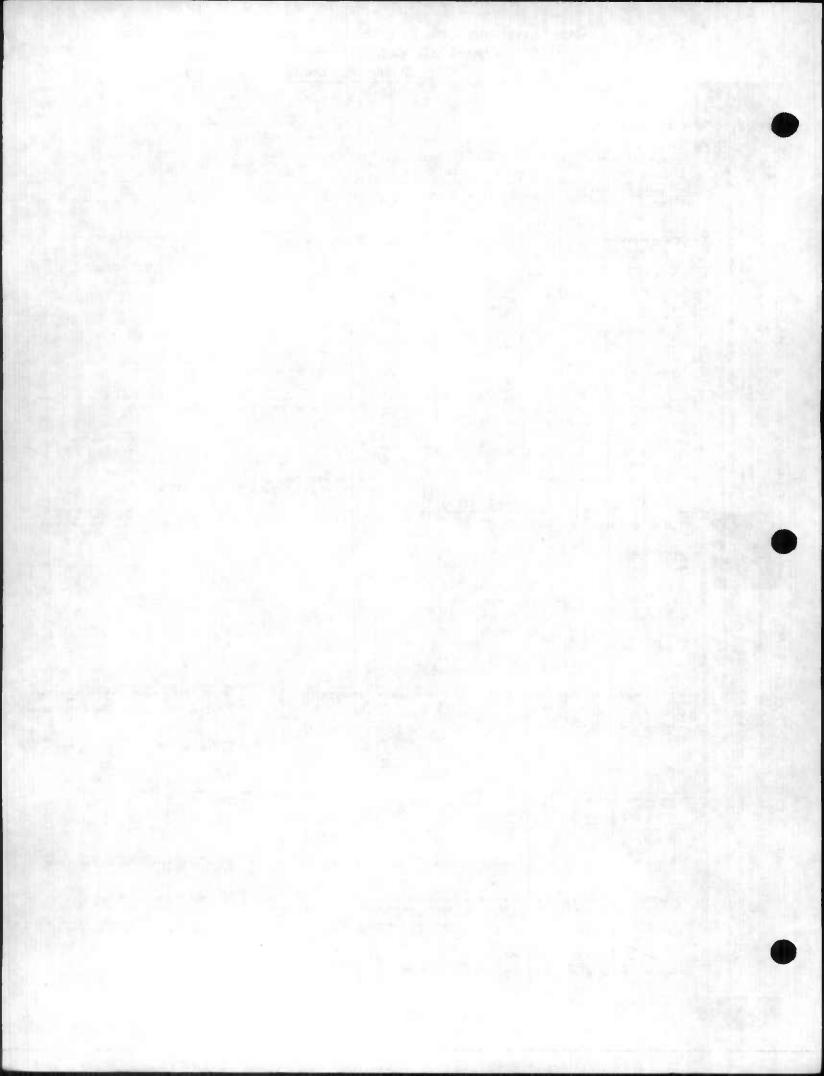
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Registrar

31. Dete filed (Month, Day, Year)

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32. Registrer's Signatura



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Yee HARRY TUCKER ebruary 23 LEE 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c County of Death Examiner Rosedale Square -Franklin 05 en Dita 0 more If Under 24 Hrs. If Under Year 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 228-26-6968 72 Virginia Director 3/ 92 Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD. Harford Bel Air 10a Street and Number 10f. Zip Code 10a, Citizen of Whet Country? 300 Sunflower Drive Apt. 350 21014 U.S.A. Funeral 12. Was Decedent Ever in U,S.
Amed Forces?
12. Yes 2 □ No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Merried 1□ Yes 2 No Specify: Specify: Caucasian þ 3 Widowed 4 □ Divorced Yeer or Dates: WW II Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Agent Real Estate 18. Mother's Neme (First, Middle, Maiden Sumeme) 17 Father's Name (First Middle Last) Be Tucker William Benjamin Shadwell Katherine 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 19a. Informant's Name/Reletionship (Type, Print) Jeffrey Tucker /Son 6017 Pt. Pleasant Road Baltimore, 20b. Placa of Disposition (Name of cemetery, cremetery or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriai 2 □ Cremation 3 □ Removal from State Jarrettsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 2000 Jarrettsville Cem. 21. Signeture of Funeral Service Licagse 22. Name and Address of Fecility mpor my ir E.G. Kurtz & Son Funeral Home, P.A. Jarrettsville, Maryland ath. Do not enier the mode of dying, such as cardiac or respiratory arrest, 23a. Pert1. Enter the disease, or complications that caused the shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final SCVI Manon disease or conditio resulting in death) Examiner Due to (or as a consequence of) Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or es e consequenca of) Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 UYSS 2 No 3 Probably 4 Unknown py 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Wes en autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 Naturel
2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pieca of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homlcide edical 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner steted. 29e. Certifier

The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records. or Attending Physician:

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Hospital

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State Registrar

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29b. Signature and tiple of cert

ess of person who completed cause of death (Item 23a) (Type, Print) 32. Redistrar's Signature

29c. License number

29d. Date signed (Month, Dev. Year)

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			State of M	Marylar		artmen rtificat			ind Men	-	ene 0 0	0	956	8		
	Division	1. Decedent's Name (First, Middle, La	st)							Dete of Death Month		Year	3. Tima o	f Death		
ġ.	Physician /Medical	Thora	Margue	rite	7	[ewel]	1			ruary			8:00	A.M.		
	Examiner	4a Facility Name (If not institution, given	e street and number	er)			4	lb. City, Tow	vn, or Locatio	on of Deeth	4c. County of	d Death				
		The Kensington	Algonqui	า					erland		Alle	gany	7			
	Funeral		Sex 7.	Age (In yrs.	last birthday)	Months Months	1 Year Deys	If Under 2 Hours	Min. 8. [Dete of Birth Month, Dey,	Year)	Coun	place (State of	or Foreign		
	Director	214-32-3720	W ZEST	86	Yrs.				Já	nuary	6,1914	P	A			
	P P	Usual Residence of Decedent 10a. Stete 10b. County		10c Ci	ty, Town or Lo	ocation					10d. Inside City Limit					
	daryfe or a ho		-1-31											2⊠No		
	vith the Ma t or 28e-f a be notified Director	MD Allega	iny	Ct	umberla	10f. Zic	Code			100	g. Citizen of W	hat Caus	10.0			
	E 80 10					101. 214				"			Hry ?			
	72 hours effect deeth with the Maryland netural; or thams 23a or 28a-1 show ideal Exercises must be notified at efed by Funeral Director	13005 Acre Lan	12. Wes Decede	nt Ever in II	16 112	Was Doos	2150		in? (Canaih)	Vac or No	USA 14 Page		an Indian.			
	Par de la constante de la cons	1 Never Merried 2 Married	Armed Force	s?	1,3.	If Yes, spe	cify Cuba	in, Mexican,	in? (Specify , Puerto Rica	n, etc.)		, White,				
2	by F	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 Ves	2⊠ No	Specify:			Specify:	Whi	ito			
ş	n 72 hours natural', of leted by	15. Decedent's E		•	16a Dece	dent's Usu	el Occup	ation		1	6b. Kind of Bus					
0		(Specify only highest gra	ada completed)		(Give	kind of wo	rk done d	during most	of working				,			
7	filed within Hygiene. there then ent, to the ent.	Elementary/Secondary (0-12)	College (1-4c	of 5+)	Sal	les C	lerk				Depar	tmer	it Sto	re		
0	be flied within 72 ho la! Hygiene. I other then "neturi event, or red Be Completed	17. Father's Name (First, Middle, Last,)					18. Mother	r's Neme (Fir	st, Middle, M	aiden Sumame					
Maryland 21215-0020	Menta Menta arked arked To B	Jesse Smith						Ar	nna Tev	well						
2	ahould be nd Mental marked o umaric eve	19a. Informent's Neme/Reletionship (19b. Meili	ng Address	S (Street	and Number	r or Rural Ro	ute Number,	City or Town, S	State, Zip	Code)			
	end 2 ealth e n 27 la er trau	Larocca Jones	(daughte	er)	415 F	Russe	11 A	ve. Ar	ot.101	2 Gait	hersbur	g, M	D 208	77		
e,	of Hard	20a. Method of Disposition		20b. I	Place of Dispo	sition (Na	me of	•			0c. Location - 0					
Baltimore,	Pages nert of it int: if he ary or or	1 ☐ Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specif		le					ab 21	2000	Cumber	land	MD F			
				[5u]						, 200φ	Cumber	Tanc	1, 110			
ă	Permit. Department importu	21. Signature of Funerel Service Licensee 22. Name end Address of Fecility Merritt-Adams Funeral Home, P.A.														
		23a Pert1. Enter the disease or com	Merritt-Adams Funeral Home, P.A. 404 Decatur St. Cumberland, MD 21502 23a. Pertl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate													
	Physician /Medical Examiner Letter be up to be	Immediate Cause (Final disease or condition resulting in death)	d	Due to (cardial oras e consec Artery oras a consec	Dise	ase	ion					5 minu 10 Yea			
5	EXB	Sequentially list conditions, if any, leading to immediate cause. Enter I Indertying		Due to (t	or as a consec	querice or).										
0000	icate be executed physician end s the burish-transit edical Examir	cause. Enter Underlying Cause (Disease or injury that initieted events	C	Due to /c	of as a consec	mence of).							_			
0	as the	resulting in death) Last		220 (0 (1		1				
DOX	use use		d							10		Tolar	Eca I	11		
0	net the death certific do by the attending pletsched for use as Physician/Mex	Part II. Other significant conditions of	ontributing to death	but not res	sulting in the u	inderlying o	ause giv	en in Pert I.		23b. Did tot	acco use con		FES (of death?		
5	by the									1 🗆 Ye	s 2 No	3 Pro	bably 4	Unknow		
ń	be de	Hypertension, Ce	erebro Va	scula	r Disea	ase										
DIVISION OF VITAL RECORDS,	aw requires to been a 2 should pleted	Osteoporosis							_	24a. Wes en perform	eutopsy ed?	av co	ere autopsy ailable prior impletion of death?	10		
	Son Page	3718 00 10 1								1 ☐ Ye	s 2⊠No	10	☐Yes 2□] No		
110	Physician: this certific ral director,	25. Wes case referred to medical examiner?							of Deeth (Ch	eck only one)					
	To To	1⊠Yes 2□NReleased		2111	ER/Outpatier			4 M IAU	-		nce 6 Othe		(y)			
=	fler the fle	27. Manner of Death 1 ⊠Neturel 5 □ Pending	28a. Dete of Ir (Month, L	ojury Day Year)	28b. Time o Injury		28c. Injun World			Describe hor	w injury occurre	d				
2	tal or Attending P re after death. el Director: After t led in by the funeri Certification:	2 ☐ Accident investigation				М	10	Yes 2 N								
2	after d Direct Jin by	3 Suicide 6 Could not b 4 Homicide determined	286. Plece of	injury - At h etc. <i>(Specii</i>	ome, ferm, sti fy)	reet, factor	y, office			Location (Str. City or Town,	eet and Numbe Stete)	r or Aure	el Houte Nun	nber,		
2	D Service															
	within 24 hours at To the Funeral D completely filled I	(Check only 2 Medical Exam	ysician: To the bes niner: On the basis	of examine										s)		
	Med mple	20h Sinnshum and title of position	and manner	steted.		200	n License	e number		20	d. Date signed	Month	Day Voer)			
	8755	29b. Signeture and title of certifier	1.													
	6	Witter	711/2		180	_	D 19	318		Fe	bruary	16,	2000			
	nas	30. Neme end address of person who								1500						
		N. A. Ranjithan		17 01	dtown 1				, MD 2	1502						
	State Registrar	31. Date filed (Month, Day Year) 200	00		B	190	acts	/								

FEB 2 2 2000 James & space

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Box 68760. 480 P.0. Records, The law requires Division of Vital this death.

1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dey Year February 21, 2000 **Physician** JOHN. RUSSELL 1:21 P.M. TURNER /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical Center Baltimore N/A If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Deys 12 M 2□ F Hours 215-04-5451 27 Director Sept. 22, 1972 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yas 2 XNo Directo Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Franciser ment be 4415 Philadelphia Rd., P.O. Box 18 21009 USA Funeral 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1⊠ Never Merried 2□ Married Baltimore, Maryland 21215-0020 natural, or 1 Yes 2√ No Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed th and Mental Hygiane.
7 is marked other than "nature traumatic avant, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry flied within Elementery/Secondery (0-12) College (1-4or 5+) Deliveryman Food Service 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Pages 1 and 2 should be I nant of Health and Mental I int: If Itam 27 ta marked of Norman Junior Turner Elizabeth Carol Schoonover 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Norman J. Turner - Father 4415 Philadelphia Rd., P.O Box 18, Abingdon, MD 21009 ham 2. 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete MBurial 2 ☐ Cremetion 3 ☐ Removel from State parmit. Page Department of Important: If any Injury or page. = 8 4 ☐ Donetion 5 ☐ Other (Specify) Harford Memorial Gardens 2/25/00 Aldino, Maryland 22. Name end Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, MD Mel 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart leilure. List only only cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner e to (or as e consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1A Yes 2□ No 1 Yes 2 No or Attending Physician: 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1⊠ Yes 2□ No Certification: To 1

Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of Injury 27. Manner of Death 28d, Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Neturel 2/2/100 /220 M2 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) Mich 1 Yes 2 No 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide filled in by 4 ☐ Homicide Word in Abirth Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner at stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edical complately (Check only one) To the F within 2 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) O.C.M.E. February 22, 2000 30. Name end address of person who completed cause of seeth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 THEODORFILL KING

DHMH 16 Rev 6/95

State

Registrar

32. Registrar's Signeture

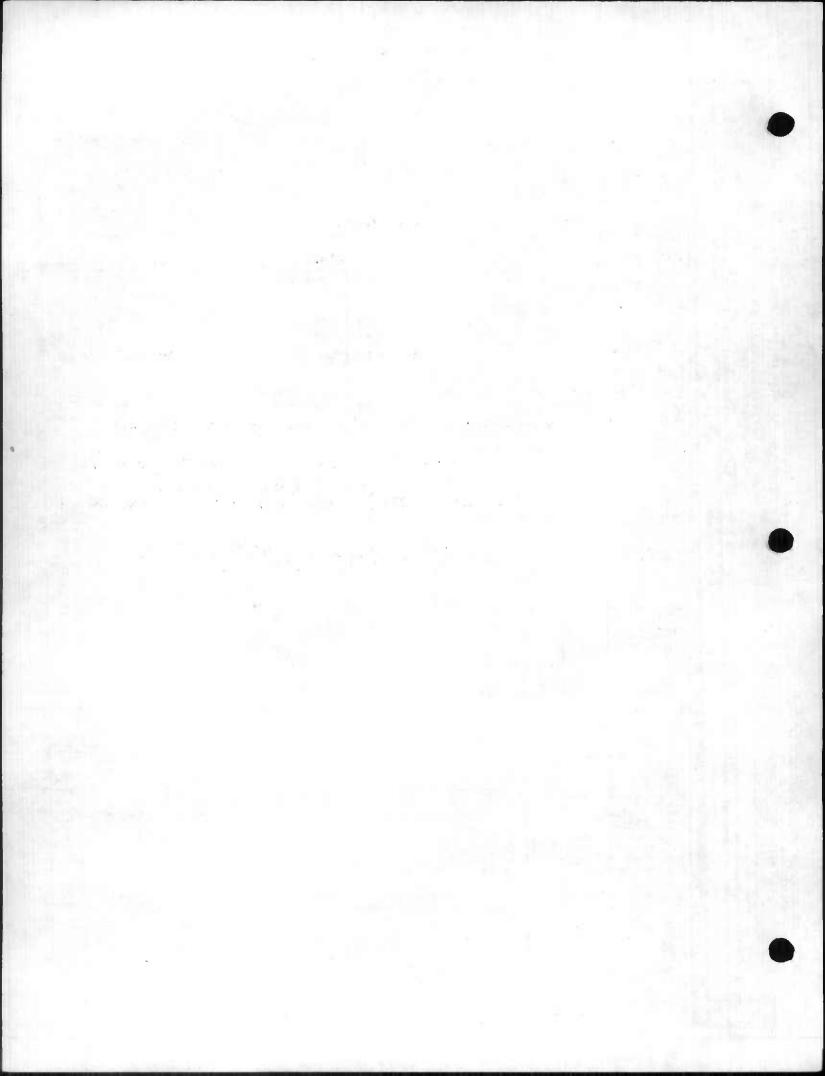
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State of Maryland / De

partment of Health and Mental H	lygiene	00	0	0	love	-7	6
Certificate of Death	Reg No		C	U	0	1	L

	Cert	ificate of Death	Reg. No.	000/10
Barrier III	Decedent's Name (First, Middle, Last)		Date of Death Month Day Year	3. Time of Death
Physician /Medical	Alma Louise Bryant Unger	Fei	bruary 22, 2000	635 pm
Examiner	4e Facility Name (If not institution, give street and number)	4b. City, Town, or Locatio	on of Death 4c. County of Death	h
	CitiZENS NURSing Hon	re Haure de	Grace Harr	ford
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. 8. D Months Days Hours Min.	Date of Birth Month, Dey, Year) 9. Birth Cod	hplace (State or Foreign untry)
Director	230-20-9735 1 M 2XF 73 Yrs.	Months Days Hours Min.	9/09/1926 Vir	ginia
9	Usual Residence of Decedent			
arylar show	10a. Stete 10b. County 10c. City, Town or Local	ition		10d. Inside City Limits
the Maryla 28s-f shorn notified	MD Harford Havre de	Grace		1 X Yas 2 □ No
15 P P P P P P P P P P P P P P P P P P P	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cor	untry?
If it death with the Maryland r thems 23s or 28s-f show siner must be notified at	4148 U-Way	21078	USA	
items in a second	11. Merifel Stetus 12. Wes Decedent Ever in U.S. 13. W. Armed Forces?	as Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Ricar	Yes or No- n, etc.) 14. Race - Amer Black, White	
of the state of th		☐ Yes 2 No Specify:	0	
5-0020 72 hours after natural; or to	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		WI	hite
	15. Decedent's Education 16a. Decede (Specify only highest grade completed) (Give ki	nt's Usuel Occupation ind of work done during most of working O NOT use retired)	16b. Kind of Business/I	Industry
within within then	Elementery/Secondery (0-12) College (1-4or 5+)			
Sold A	12th Home	emaker	Home	
E da	17. Eather's Name (First, Middle, Last)		st, Middle, Maiden Sumame)	
Via Nem Men			lizabeth Wright	
Aaryland 212: 2 should be filed within and Mental Hygiene. In marked other than reumatic event, the Mercomp		Address (Street and Number or Rural Ro	ute Number, City or Town, State, Z	(ip Code)
re, Maryland 212: s 1 and 2 should be filed within if Health and Mental Hygiene. fem 27 le marked other than other traumatic event, the the Taumatic event, the Taumatic event, the the Taumatic event, the Taumatic event, the the Taumatic event, the Taumatic e		J-Way, Havre de G		
Pes 1	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposic cemetery, cremation	atory or other place)	ate 20c. Location - City or 1	Town, State
Pag Pag ment: uny oury		I Cemetery 2/26	6/00 Berryville,	VA
Baltimore, Noemit. Pages 1 and Department of Health Important: if item 27 any injury or other transcent.	21. Signature of Funerel Service Licensee 22.	Name end Address of Facility		
D 88558	Julaine in Smith 123	tchell-Smith Funera S. Washington, Ha	I Home, P.A.	AD 21079
	23a. Pert). Enter the diseese, or complications that caused the death. Do not enter shork, or hear failure. List only one cause on each line.	the mode of dying, such as cardiac or res	spiretory errest,	Approximate
Physician				Intervel Between Onset and Death
/IVIedical	Immediate Cause (Final	NO WITH META	154ASIS !	
Examiner	disease or condition resulting in death) Due to (or as a consequence)		71.77	
Name of the last	Due to (or as a consequ	silve oi).	1	
owecied in and intransit	Sequentially list conditions. Due to (or as a consequence)	ence of).		
60, be execu- ician and burtai-tra	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.			
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Be and the bear	resulting in death) Last			
Box sett car strandin for use	d			
. 5 .0 -	Part tt. Other significant conditions contributing to death but not resulting in the unc	lerlying cause given in Part I.	23b. Did tobacco use contribute	to the cause of death?
P.O.		S. J. I. J. L.		robably 4 Unknown
6 80 -			10100 20100 1011	
Division of Vital Records, or Attanding Physician: The law requires taker death. Director: After this certificate has been signification the funeral director, page 2 should be ertification: To Be Completed by				Were autopsy findings
v requ			,	completion of cause of death?
The law require has been a page 2 should		And the little of the little		0.1
Court The Court			1 Yes No 1	1 □ Yas 2 No
Vital Re- statem: The law certificate has freedor, page 2 0 Be Comp	25. Was case referred to medical exeminer? Hospitet:	26. Place of Death (Ch		
Phys of	1 Inpatient 2 ER/Outpatient	3LI DOA JOSLINUISING Home	5 ☐ Residence 6 ☐ Other (Specified how injury occurred	city)
Division of the control of the contr	1) Alaturel 5 Pending (Month, Day Year) Injury	28c. tnjury at Work? M 1 Yes 2 No	Describe now injury occurred	
ISIG	2 Accident investigation 3 Suicide 8 Could not be		Location (Street and Number or Ru	ural Pauta Number
Division or Attendant after death Directors in by the ertifical	3 Suicide 4 ☐ Homicide	it, rectory, office	City or Town, State)	oral Hobie (Vulliber,
Houpital or 14 hours after Funeral Dir sely filled in lical Cert	29a. Certifier Certifying Physician: To the best of my knowledge death of	parameter the time data and alone and a	due to the enumeral and manner or	atatad
e Hosp n 24 hos s Fune pletely fi	29a. Certifier (Check enly one) Check enly 2□ Medicat Examiner: On the basis of examinetion and/or invested and anner stated.	stigation, in my opinion, death occurred at	the time, date and place, and due	to the cause(s)
To the Hospital within 24 hours To the Funeral completely filled Medical C	29b. Signeture and title of certifier <	29c. License number	29d. Date signed (Mont/	Day, Year)
F 3 F 8	1 Pupan A A MAN	1112800	7/22/	4
7	2.1-01000 1000	DJA OU	0/00/0	0
16	30. Name and address of person who completed cause of death (ttem 23a) Type, Pi	int)//A 7/170	/ /	
(1/101	21 Data Had March Day York	my 21018		
State	31. Date filed (Month, Dey, Year) 32. Registrar's Signatura	9. South		
Registrar		pour		



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Daath Day **Physician** Month Yaar 24, Edna Boly Wheeler Feb. 2000 3:30 A.M. /Medicai 4a. Facility Name (If not Institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Health Srevices Potomac Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Yeer) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F 93 Yrs. Director 226-42-4146 Feb. 28, 1906 St. Louis, MO Usual Residence of Decedent with the Maryland 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show rai', or items 23a or 28a-f shore Examiner must be notified at MD Montgome ry Po to mac 1 ☐ Yes 2 ☑ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10714 Potomac Tennis Lane 20854 U.S.A. Funeral death 11 Maritai Status 12. Was Decedant Evar in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 72 hours after 1 Yas RNo If Yes, Give Year or Dates: 1 ☐ Navar Marriad 2 ☐ Married Maryland 21215-0020 1 Yas 2 No Specify: by X□Widowed 4□Divorced Specify: "natural". White Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within ond Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+Teacher Education 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be Peges 1 and 2 should be in nent of Heelth end Mentel I Jefferson D. Boly Mary Anna Boehling 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zlp Code) Willis Wheeler / Son nt of Heelth 4801 Hampdon Lane Apt. 702 Bethesda, MD 20814 other 1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 0 1 Burial 2 □ Cremation 3 □ Removal from State permit. Pege Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) National Memorial Park Feb.28.00 Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Pearson Funeral Home Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Falls Church, VA 22046 Approximate triterval Between Onsat and Death Physician /Medicai immediate Cause (Final Alcan usalt disease or condition resulting in death) Examiner Due to (or as a consequence of): DEHYDRATION The law requires that the death certificete be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last pue Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. ettending physician for use es the burie Physician/Medical Dua to (or as a consequence of): signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? page 2 2 2 No ate 1 Tyes 1 Yes 2 No Attending Physician: certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Natural 5 Panding Invastigation death. 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 To the Hospital o within 24 hours eff To the Funeral DI completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Wedical 29b. Signature and title of cartifier 29c. License number 29d. Date signed (Month, Day, Year) 25-2000 H51280 30. Name and address of person who completed caust of death (Item 23a) (Type, Print)

Dr. Anushiravan Dadgar 13219 Executive Park Terr. Germantown, MD 20874 31. Date filed (Month, Pay, Year) FEB 2 9 32. Registrar's Signature State 2000 souks Registrar

DHMH 16 Bev 6/95

AMENDED ITE	State of Maryland / Department of Health and I MS #7,8,18 PER FH G781 3/21/2000 AH Certificate of Death	Mental Hygiene 00 08572
Physicial	William Wilson	2. Data of Death Month Feb. 29, 2000 Year 1:20 AM.
/Medica Examine	de English Name // and institution give street and number)	
	Mariner Health Care - Grosvenor Bethesda	
Funeral Director	5. Sociel Security Number 6. Sex 1 M 2 F 7. Aga (In yrs. last birthday) 1 Under 1 Yaer 1 If Under 24 Hrs. Months Deys Hours Min.	
E	Usual Rasidence of Decedent 10a. Steta 10b. County 10c. City, Town or Location	10d. Insida City Limits
with the Marylar a or 28a-f show Lbs.notified.at		1 ☐ Yas 2 ☑ No
h the r 28a	Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Coda	10g. Citizen of What Country?
ith will 23a c		U.S.A.
Maryland 21215-0020 d 2 should be filed within 72 hours atter death v b and Mental Hydlene. T is marked other than "natural", or items 23, treumstic event, the Medical Examiner must To Be Completed by Funeral	W. O	pecity Yas or No- to Rican, atc.) 14. Race - American Indien, Black, Whita, atc. Specity: White
		16b. Kind of Business/Industry
21 20 will	4 Economist	U.S. Civil Service
Dug Hall	17. Fathar's Name (First, Middla, Last) 18. Mother's Name (Control of the Control of the Contro	ma (First, Middla, Meiden Surname) 11a Munoz MARTH De WITT
Tylia d Market		ural Routa Number, City or Town, Stata, Zip Coda)
Andrew W. Wilson - Son Two Columbus Ave. #		8B, New York, NY. 10023
altimore, mit. Pages 1 at partment of Hea portent: if Nem: y Injury or other	20b. Mathod of Disposition 20b. Place of Disposition (Nama of cematery, crametory or other place)	Data 20c. Location - City or Town, Stata 3/2/2000 Alexandria, VA
Physician Medical Examiner Medical Examiner Description Descript		oseph Gawler's Sons, Inc.
		Onsat and Deeth
d d ansit	Sequentially list conditions b. Dua to (or as a consequence of):	
SO, se exect sien an unial-tr	if any, laading to immadiata	
certificate be a ding physicien as as the buria	Cause (Disease or injury that initiated avants resulting in death) Last Due to (or as a consequence of): d. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown	
Box 6	d	
. B	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying causa givan in Part I.	23b. Did tobacco use contribute to the cause of death?
		1 Yes 2 No 3 Probably 4 Unknown
Cord requir		24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to complation of ceuse of death?
Vital Recicion: The levicenticate has		1 Yas 2 No 1 Yes 20 No
f Vital Respectan: The Hall Scentificate hadinector, page	25. Was casa refarred to medical 26. Plece of De	ath (Check only ona)
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The state of	27. Manner of Death 28a. Date of Injury 28b. Tima of Injury 28c. Injury at Work? Work? 1 Accident investigation Work?	28d. Dascribe how injury occurred
Division catending Para at Director. After the funerical field in by the funerical catendary cat	2 Accident investigation 3 Suicida 6 Could not be datarmined 28e. Place of Injury - At home, farm, straat, factory, office building, atc. (Specify)	28f. Location (Street and Number or Rural Routa Number, City or Town, State)
Hospi A hou Funer tely fil	29a. Certifier 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
To the within 2 To the comple	29b. Signature and title of cartiflar 29c. Licensa number	29d. Date signed (Month, Day, Year)
10	Mully H51280	2-29-2000
	30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)	
Carr	Anushiravan Dadgar, MD. 13219 Executive Park Drive, G 31. Data filed (Month, Day, Year) 32. Registrar's Signatura	ermantown, Md, 20874
State Registra	WAD 0.0 2000	

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A Comment · PARSTA

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day **Physician** Kenneth C. Wimmel March 2, 2000 2:05 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Undar 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 110 M 20 F 289-34-2798 66 Aug. 12, 1933 Director Ohio Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. toside City Limits Maryland | Montgomery 1 Yes 2 No Directo Bethesda 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? re 23a or 5705 Maiden Lane 20817 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. 1 Never Married 2 Married 21215-0020 ò 1 Yes 2k No Specify: Specify by 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Dept. of State 5+ Foreign Service Officer Baltimore, Maryland 17 Fether's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 Pages 1 and 2 should be nent of Health and Mental Louis C. Wimmel Ethel Wetterstroem 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a if Item 27 is or other tra Arati Wimmel/Wife 5705 Maiden Lane, Bethesda, Maryland 20817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State March 3, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or 4 Donation 5 Other (Specify) 2000 Montgomery Crematorium, Inc. Bethesda, Maryland 22. Nama and Address of Fecility
Robert A. Pumphrey Funeral Home/Bethesda-Chevy
T557 Wisconsin Avenue
Bethesda. Maryland 20814-3501

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast,

Approximate
Interval Service Licensee Approximate Interval Between Onset and Death **Physician** Immediata Causa (Finel disease or condition resulting in death) /Medical SEPSIS 2 WEEKS Examiner Due to (or as a consequence of): Examiner MYELOMA MULTIPLE Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es a consequence of) physician Physician/Medical the Due to (or as a consequence of): 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yea 20 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Completed this certificate has 1 Yas 2 100 1 □ Vas 2 □ No Vital director. Be 25. Was case refarred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Certification: To funeral 27. Manner of Death 1 Divatural 28b. Tima of Injury 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? Division Attending 5 Pending investigation death. 1 TYes 2 □ No 2 Accident i or Attend after death Director: 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours at To the Funeral D completely filled i 1th Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. Licanse number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 02 2000 Taluran M.D. D 36552 15 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockville MD. 20852 50 W. Edmonston #401 P. TALWAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 3 2000 seneva souls Registrar

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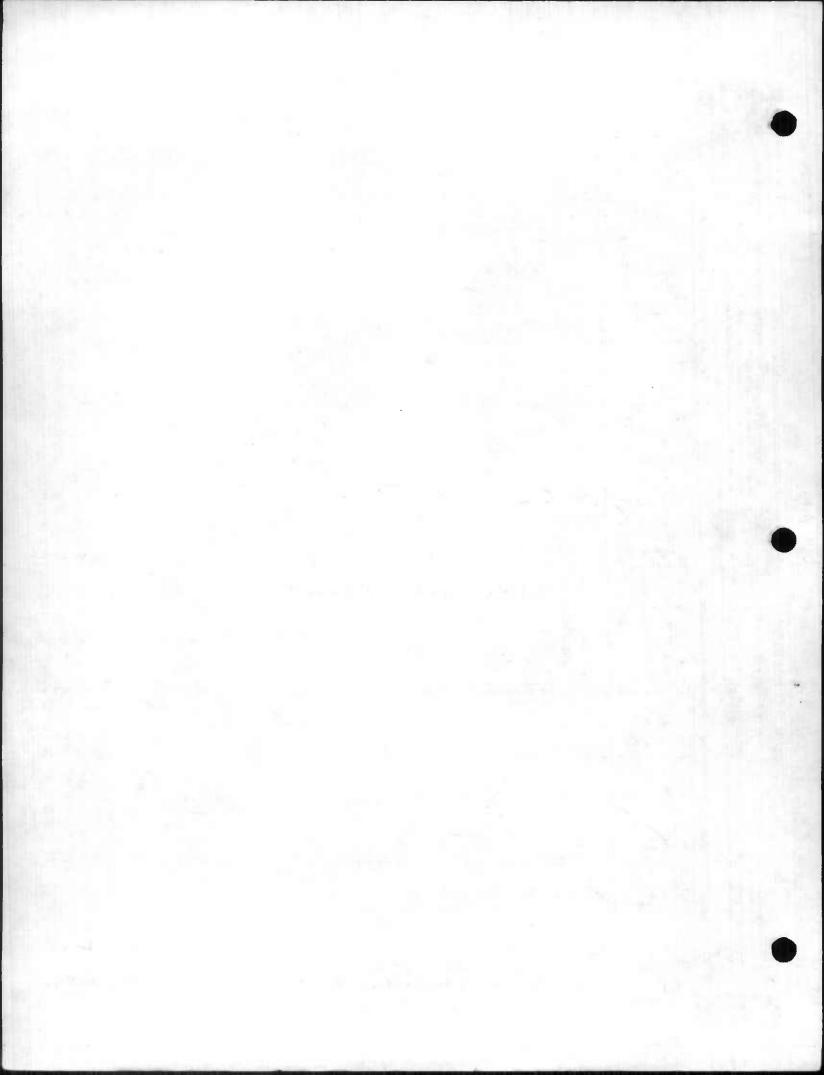
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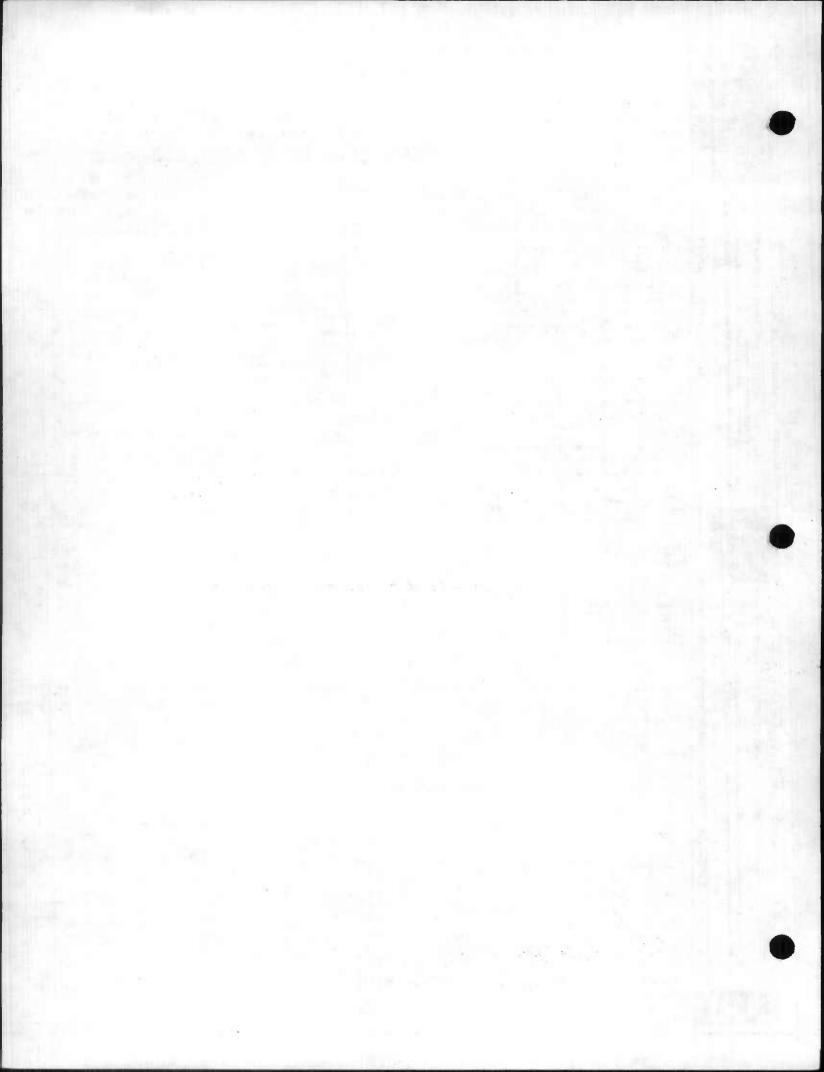


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State of Maryland / Department of Health and Mental Hygiene 0 0 85

			Name (First, Middle, La	st)		Certi	ficate of	Death	2. Date of Dea		Year	3. Time of Death		
	Physician /Medical	Sams	sun Wo	ng					Februar			7:30am		
	/Medical Examiner	4a Facility Na	me (If not institution, giv		er)			4b. City, Town, or	Location of Death	4c. County of				
	Examine	1218 T	wig Terra	ace			1.5	SILVER S	SPRING	MONTGO	MER	Y		
	Funeral Director	5. Social Security Number 5. Social Security Number 1 M M 2 F 7. Age (In yrs. last birthday) 39 Yrs. 6. Sex 1 Months Days Hours Hunder 24 Hrs. (Month, SEPT.								7. Year) 9, 1960	9. Births Cour VII	place (State or Foreign ntry) ETNAM		
	styland the styland the styland	10a. State 10b. County 10c. City, Town or Location									1	10d. Inside City Limits 1 ☐ Yes 2 📆 No		
	Paris Maria	TID	HONTGOM	21/1	SILV	EK SIN	IING					T Tes ZLANO		
	th with the Mer 23a or 28a-f si as be notified al Director			RRACE			10f. Zip Code 20905	;		USA	hat Cou	ntry?		
020	filed within 72 hours after death with the Meryland Hygiene. ther than "natural", or items 23s or 28s-f show and, the Medical Energies must be notified as Completed by Funeral Director.	3 ☐ Widow	itus Married 2∑ Merried ved 4 □ Divorced	12. Wes Deceder Armed Force 1 Yes 2 HYes, Give Yeer or Detes	S? Ano		s Decedent of es, specify Cut Yes 2 No		Specify Yes or No- rto Rican, etc.)	14. Race Black Specify:	, White,			
2-0	ed within 72 hours ygiene. The transfer of th	,	15. Decedent's Ed	Education 16a. Decedent's Usual O (Give kind of work dife. DO NOT use re				pation	ndina	16b. Kind of But	siness/In	dustry		
2	hin 7	Elementary/	Secondary (0-12)	College (1-4or 5+)		life. DO NOT use re		retired)						
7	Hygiene. ther than the, the M	11				AUTO	MECHAN]	C		AUTOMOT	IVE			
B			ame (First, Middle, Last,)			1111	18. Mother's Na	ame (First, Middle,	Maiden Surname)			
ā	Mental Mental arked o	KHAM T	• VUONG					NGA HI	JYNH					
Maryland 21215-0020	d 2 sh th and 7 is m trsum		t's Name/Relationship (A WONG (SE	Type, Print) POUSE)		19b. Mailing /	The state of the s			r, City or Town, State, Zip Code) RING, MD 20905				
Baltimore,	-155	20e. Method of	t Disposition		20b. Plac	e of Dispositi	on (Name of		Date	20c. Location - 0	City or To	own, State		
9	@ O L		1\(\text{Denotation} \) 2 \(\text{Cremation} \) 3 \(\text{Removal from State} \) Cemetery, crematory or other place) 4 \(\text{Donation} \) 5 \(\text{Other} \) (Specify) Cemetery, crematory or other place) GATE OF HEAVEN CEMETERY 03/11/00 SILVER SE											
	artmen ortant: injury													
Ba	permit. Page Department of Important: If any injury or pose.	P	105	2///1/			AVENUE	SILVER S	SPRING, M	D 20904) NEV	N HAMPSHIRE		
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	Physician		Onset and Death											
	/Medical	Immediate Ce disease or cor	use (Finel					6 weeks						
	Examiner	resulting in death) Due to (or as a consequence of):												
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	ificate be executed g physician and es the buriel-transit edical Examiner	Sequentially li	st conditions,	Ь		s a conseque					1			
oʻ	an an iniel-i	if any, leading cause. Enter	to Immediate Underlying						1					
68760,	ficate be physicians the bur	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):									1			
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	death cer e sttendin ed for use	Part II. Other s	her significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobecco use contribute to the c			to the cause of death?		
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of Vital Records,	been sign should be								24a. Was perfo	an autopsy med?	8/	Vere autopsy findings vailable prior to ompletion of cause I death?		
Ĭ	The law ate hes page 2	P 100							101	es 2 No	1	☐ Yes 2☐ No		
ā	certificate rector, pag		referred to medical					26 Place of De	eath (Check only o					
>		examiner?		Hospital: 1 ☐ Inpa	tiont 2DEB	/Outpatient	3 D DOA 01	hor	Home 5 Resid		r (Spani	iA.1		
	eath. or: After this c the funeral dire cation: To	27. Manner of 1 Natura	Death I 5 ☐ Pending	28a. Date of Ir (Month, L	iury 28	b. Time of Injury	28c. Inju		1	now injury occurre	-	,,,,		
Division		2 Accide 3 Suicid 4 Homic	le 6 Could not b	e 28e. Place of I	njury - At home etc. (Specify)	e, farm, street	t, factory, office	100	28f. Location (S City or Tox		er or Run	ral Route Number,		
		29a. Certifier	15 Certifying Ph	clan: To the bes	at of my knowle	dge, death or	ccurred at the t	ime, date and place	e, and due to the	cause(s) and man	ner as s	stated.		
	in 24 houns file fune spletely filedical	one)	1/1///	and manner	stated.	anwor mives	agaion, ai my	Openion, Gostin Oct	ones at the time, t	outo ariu piaco, a		- and cadad(s)		
	To the comple	29b. Signatur	ghoppia of Eartiful		4. 1		29c. Licen	se number		29d. Date signed	(Month,	Day, Year)		
		14//	1 / Wale	1111 11	11)		D08	3754		March 1	20	00		
	10	30 Name and	address of person who	ompleted cause of	death (Item 23	Ba) (Type, Pri	int)							
			A. Bensing					r Dr C	reenbelt	, MD 20	770			
	State		(Month, Day, Year)	32. Regis	trar's Signature	9 4								
	Registrar		MAP 0 3 20	nn Zin	war	D	doorks							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🖺 🗎 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death February 37 Joso 8:55Am **Physician** BRENDA WOODLAND ANN /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LANHAM DOCTOR'S HOSPITAL P.G. Months Days Hours Min. JUNE 1994 10 5. Sociel Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stete or Foreign **Funeral** Months 1□M 2√2F 59 MARYLAND 213-40-6427 Yrs. Director Usuel Rasidance of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD P.G. FT. WASHINGTON Director 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò must be 3607 STONESBORO ROAD 20744 USA Berns 23s Funeral 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedant Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Hygiene. ther than 'natural', or iten ent, the Medical Examiner 1 ☐ Yes 2 XNo If Yas, Give 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Yaar or Datas: Completed 16a. Decedant's Usual Occupation (Givs kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast greda completed) Elementary/Secondery (0-12) Collega (1-4or 5+) UNIT CLERK/HEALTH AID HUMANNA HEALTH SER 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Fages 1 and 2 should be in ment of Health and Mental H ant. If item 27 is marked off lury or other traumatic ever Be THOMAS ANDREW WOODLAND BERTHA ELIZABETH BARNES 2 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) WANDA CULLEY -daughter 10909 TIMBERLINE DR. UPPER MARLBORO, MD. 20772 20b. Place of Disposition (Nama of 20a. Method of Disposition Data 20c. Location - City or Town, State 1 X Burlal 2 □ Cramation 3 □ Ramoval from Stata OLIVET CEMTERY3/3/2000 WASHINGTON, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fureral Service Lice 22. Name and Address of Fecility
AUSTIN ROYSTER FUNERAL HOME 3821 14TH ST. N.W. WASH, 20011 sa, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, a. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediata Cause (Final METASTATIC COLON CANCER 2 YEARS disaesa or condition rasulting in deeth) Examiner Dua to (or as a consequence of): Examiner LIVER METASTA B.15 pue Sequentially list conditions, if eny, laeding to immadiata causa. Entar Undarlying Cause (Disaase or Injury that initiated evants resulting in death) Last Dua to (or as a consequence of): LUNG Box 68760. HETASTASIS Physician/Medical Dua to (or as a consequanca of): 8 PERITONEAL CARCINOMATOSIS use signed by the a 23b. Did tobacco usa contributa to the cause of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 1 Yas 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 Yes 2 No certificate or Attending Physician: Be 25. Was casa rafarred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After Division 1 Naturel 5 Pending invastigation after death. 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 2 4 Homicida

rilled in within 24 hours at To the Funeral D completely filled i Hospital \$ 0

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

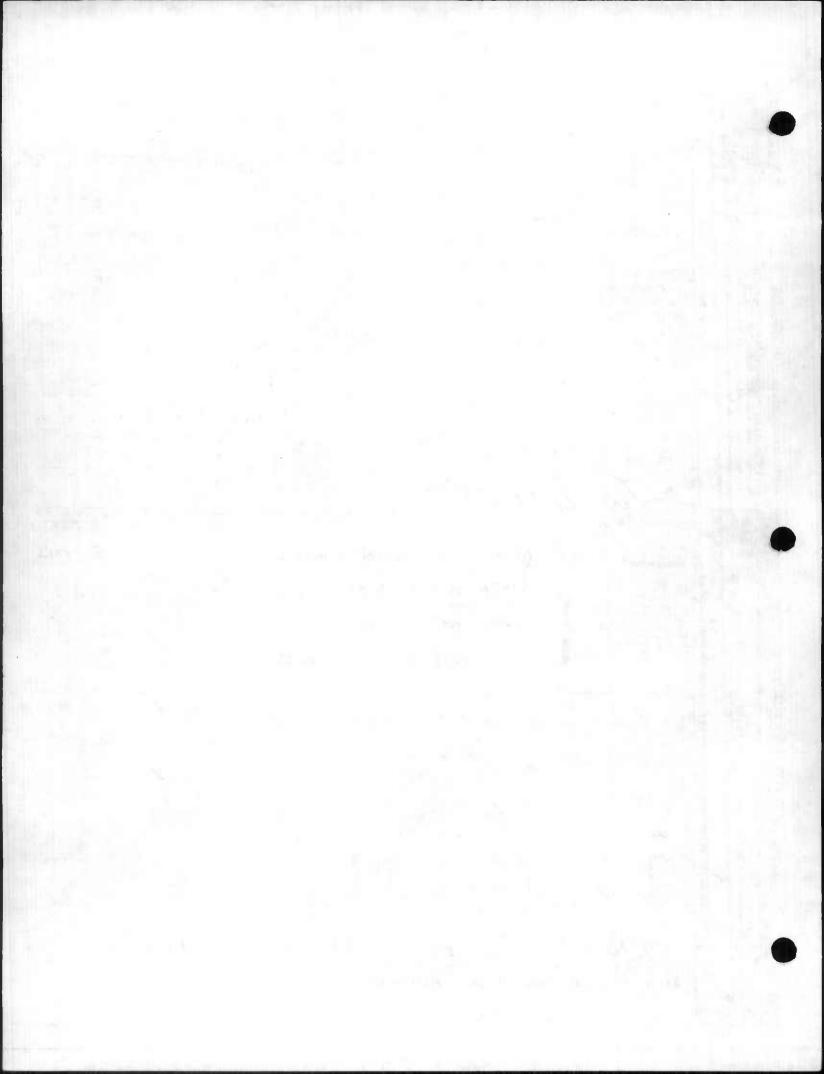
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier D43162 2/28/00 MO hum Gaskins, Melvin W. 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) #230 HITCHELLVILLE, MO AVE CENTRAL 31. Data filed (Month, Day, Year)

State Registrar

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32. Registrar's Signetura

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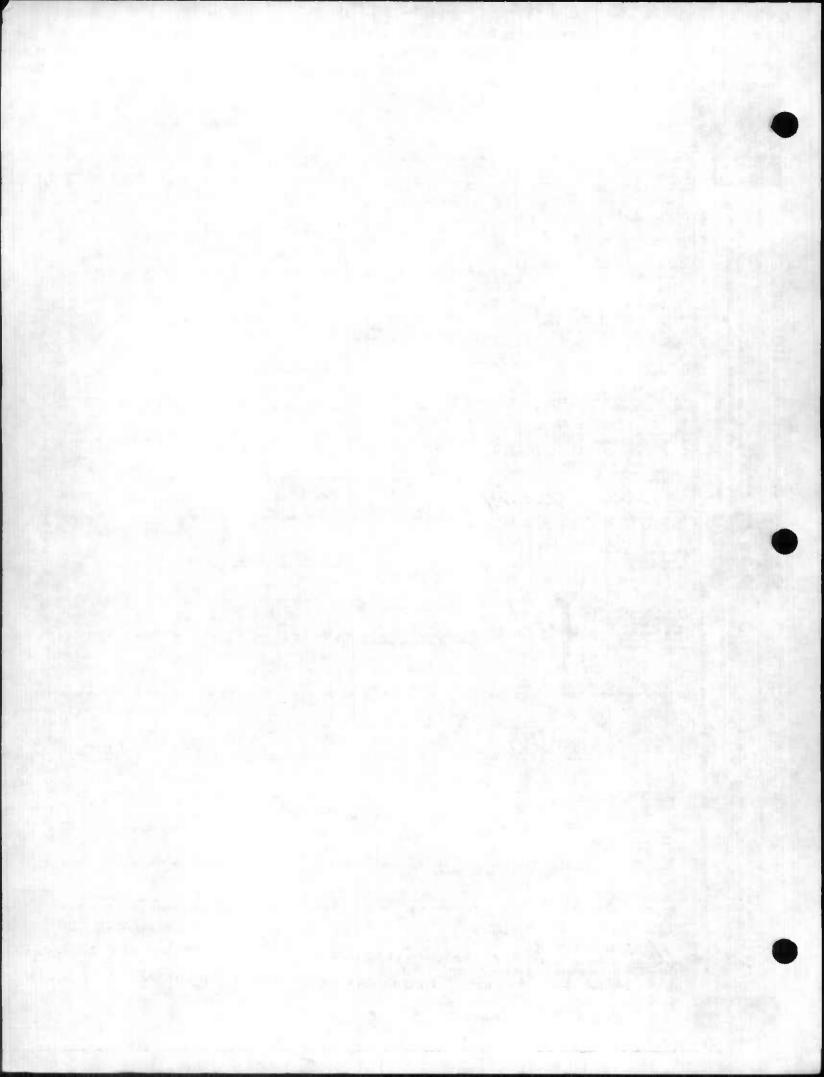
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State of Maryland / Department of Health and Mental Hygiene

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					Cei	rtificate of	Death		Reg. No.			
		1. Decedent's Nama (First, Mide	die, Last)			May 45		2. Data of Do Month	eath Day	Year	3. Time of Death	
	Physician	Leatha Opal Wy	att						ary 23,		2:40 PM	
	/Medical Examiner	4a Facility Nama (If not institution	on, giva street and no	um <i>ber</i>)	7-10,00		4b. City, Town,	or Location of Dea	-			
	LAdiiiiici	SHADY GR	OVE ADVE	NTIST	HOSPI	TAL	ROCKV	TILLE	MON	rgom	ERY	
-	Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Yaar	If Under 24 H	irs. 8. Date of Bi	rth	9. Birthp	lace (State or Foreign	
	Funeral Director	214-48-8342	1□ M 2⊠ F	89		Months Days	Hours N	March	ay, Year) 19,1910	Coun	lace (State or Foreign try) Virginia	
	Director	Usual Residence of Decedent						Haren	10,1010	NESC	VIIgIIIIa	
	E Bu	10a. State 10b. Count	у	10c. Cit	ty, Town or Lo	ocation				1	Od. Inside City Limits	
	dany or sea	Maryland Mon	tgomery		Ro	ckville					1 X Yas 2 □ No	
	or 28a-fa be notified	10e. Street and Number	-8001)		100	10f. Zip Code			10g. Citizen of V	Vhat Cour	itry?	
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	ther death references the funeral	921 Veirs Mill					0851	10-11-11	United			
	und Mer	11. Marital Status	12. Was Dec	cedent Evar in U forces? 2 📉 No	1,5.	Was Decedent of If Yes, specify Cut	pan, Mexican, Pu	(Specify Yes or Nuarto Rican, etc.)	Blac	k, White,	en Indian, etc.	
20	1 5 E M	1 Never Marriad 2 Ma	If Yes, G	iva	10	1□ Yes 2₺ No	Specify:		Specify	. W	hite	
00	Francis de by	3 X Widowed 4 ☐ Divorce	d Yaar or	Dates:								
To.	ed within 72 ho ygiene. ye then "neturn it, the Medical Completed		nt's Education est grade completed)	16a. Dece	dent's Usual Occu kind of work done DO NOT use retire	pation during most of	working	16b. Kind of Bu	isiness/Ind	dustry	
2	IN IN	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retire	ed)					
N	No. of	8				Homemak	er			own H	ome	
P	E145 0	17. Father's Name (First, Middle	, Last)				18. Mother's I	Name (First, Middle	e, Maiden Surnam	a)		
-	Annia	William Lewis	Sheaves				Lydia	a Carolin	e Hanshe	w		
Maryland 21215-0020	of but	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailie	ng Address (Stree	t and Number or	Rural Route Numi	ber, City or Town,	State, Zip	Code)	
	all all a	Joanne S. Wyatt	t/Daughter		921	Veirs Mi	11 Road	, Rockvil	le. Mary	land	20851	
0	Han Han	20a. Method of Disposition		20h F	Place of Dispo	sition (Name of		Date	20c. Location -			
9	or it of	1 Burial 2 Cremation		Sigia		matory or other pla Memorial		Feb. 28,	C1 i	To IT-	-to Vitared at a	
Baltimore,	d and control	4 Donation 5 Other (Wa							st Virginia	
Bal	no de la company	21. Signature of Funeral Service	e Licensee	//	P P	ockwille	Tnc	300 West	Yumphre	y ru	neral Home/	
-	40200) mun_z	- Dorier	M00	672 R	ockville	, Maryla	300 West and 2085	0-2805	iery	Avenue,	
		23a. Part1. Entar tha diseasa, o shock, or heart failure. Lis	or complications that	caused the deat	th. Do not ent	ter tha moda of dy	ing, such as cere	diac or respiratory	arrest,		Approximate Interval Between	
Y	Physician									1	Onset and Death	
N.	/Medical	Immediate Cause (Final	stom Fail	1120	1	4 Days						
	Examiner	disease or condition resulting In death) Septic Shock With Multi-Organ System Failure Due to (or as a consequence of):										
	<u> </u>			/ Darra								
	ding physician end sa as the bunal-transit		b	epsis		Tuence off:					4 Days	
	al-tra	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury c.										
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TO	certificate rector, pag	25. Was cese referred to medic		<u> </u>			26 Place of	Death (Check only	The seasons of			
Vital	Physician: this certific ral director. :: To Be (axaminer? 1 ☐ Yes 2 ☒ No	44 3 4	Inpatient 2	I E D (O	nt 3 DOA O	ther:			as (Casali	50	
ō	Physic chils control direction of the To	27. Manner of Death			28b. Tima o	III JUDON	- INDISH	ng Home 5 ☐ Res	how injury occur		γ)	
L C	After fune	1 ⊠Natural 5 □ Pend		of Injury nth, Day Year)	Injury		ury at ork?] Yes 2 ☐ No					
S	Attending or deeth. ector: After by the fune	3 Sulcide 6 Could	tigation and the	4 to 5 As to	100			29f Location	(Street and Numb	or or Dum	I Poute Number	
Division	tal or Attending P is after deeth. In Director: After t led in by the funera Certification:	4 Homicide deter	mined 28e. Plac	e of Injury - At h ding, etc. (Specil	iome, farm, sti fy)	reet, factory, office		City or To	own, State)	er or mun	ir Houte (vuntber,	
	C lied											
	n 24 hound no 24 h	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: To th I Examiner: On the I	e best of my kno basis of examina	wiedge, deat	h occurred at the t vestigation, in my	ime, date and pl opinion, death o	lace, and due to the occurred at the time	e cause(s) and ma e, date and place,	anner as a	tated. o the cause(s)	
	To the Hospital or Attending Phwithin 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 7	-	l Examiner: On the i									
	With To the Com	29b. Signature and title of certific	Le Davo	en			ise number	0112	29d. Date signe			
	7/	Maurona	- MITIE	AT CAN	15) CS	WILLIAM	VI U)	UIIL	FEBRU,	ARY	23 2000	
		30. Name and address of person	n who completed cau	use of death (Iter	m 23a) (Type.	Print)				0 4		
		VIRENDRA		ENM,	71001	DEER CR	OSSINC	5 C7. 13	ETITESDA	1 1	23 2000 ND 20817	
	State	31. Date filed (Month, Day, Year		Registrar's Signa		-						
	Registrar	FEB 28	2000	mera	19.	Spork	/					

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month 28, 6:11 am 2000 Barbara Ann Webb Feb 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Carroll County General Hospital Westminster Carroll If Under 24 Hrs. If Under 1 Year 5. Social Security Number Date of Birth (Month, Day, Year) Oct 14,1946 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1□ M 2⊠ F 218-44-6263 Yrs 53 West Virginia Usual Basidence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits Manchester 1 ☐ Yes 2 No Maryland Carroll 10e Street and Number 10f Zip Code 10n Citizen of What Country? 3837 Maple Grove Road 21102 TISA 14. Rece - American Indien, Black White atc. 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 20 No If Yes, Give Year or Datas: 1 Never Married 2 XMerried White 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Webbs Tree Service Part Owner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) William Charles Marie Gearheart 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Howard Webb, husband 3837 Maple Grove Rd, Manchester, MD 21102 20b. Plece of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 D'Buriel 2 □ Cremetion 3 □ Removel from Steta 3/2 4 ☐ Donetion 5 ☐ Othar (Specify) Evergreen Memorial Gard Finksburg, MD 22. Name and Address of Facility M00723 Eline Funeral Home 934 South Main St, Hampstead, MD 21074 e 23a. Pert1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disaase or condition resulting in death) Asthuticus Due to (or as a consequence of) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of) Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. JUYOS 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy 20 No 1 ☐ Yes 1 TVes 2 No 25. Wss case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 2□ ER/Outpatient 3□ DOA 1 Yes 2 No 1 Inpatient

Physician /Medical Examiner

and

attending physician

that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

r then "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

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Pages 1 and 2 should be to nent of Health and Mental I int: If Item 27 is marked of

nt of Health a: If Item 27 is

permit. Page Department of Important: If any injury or page.

Baltimore, Marviand 21215-0020

Examiner Physician/Medicai Àq Be Certification: To

Completed 27. Menner of Death

the signed by the a

been si page 2 certificata Mospital or Attanding Physician:
 24 hours after death.
 Funeral Director: After this certifical eleiy filled in by the funeral director. F.

29a. Certifier (Check only one)

Medical

12 Netural

2 Accident 3 Suicide 4 Homloide

5 Pending investigation 6 Could not be determined

28a. Dete of Injury (Month, Day Year)

28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

281. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Madical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated.

29d. Date signed (Month, Day, Year)

28

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28d. Describe how injury occurred

29b. Signatura and title 29c. License number

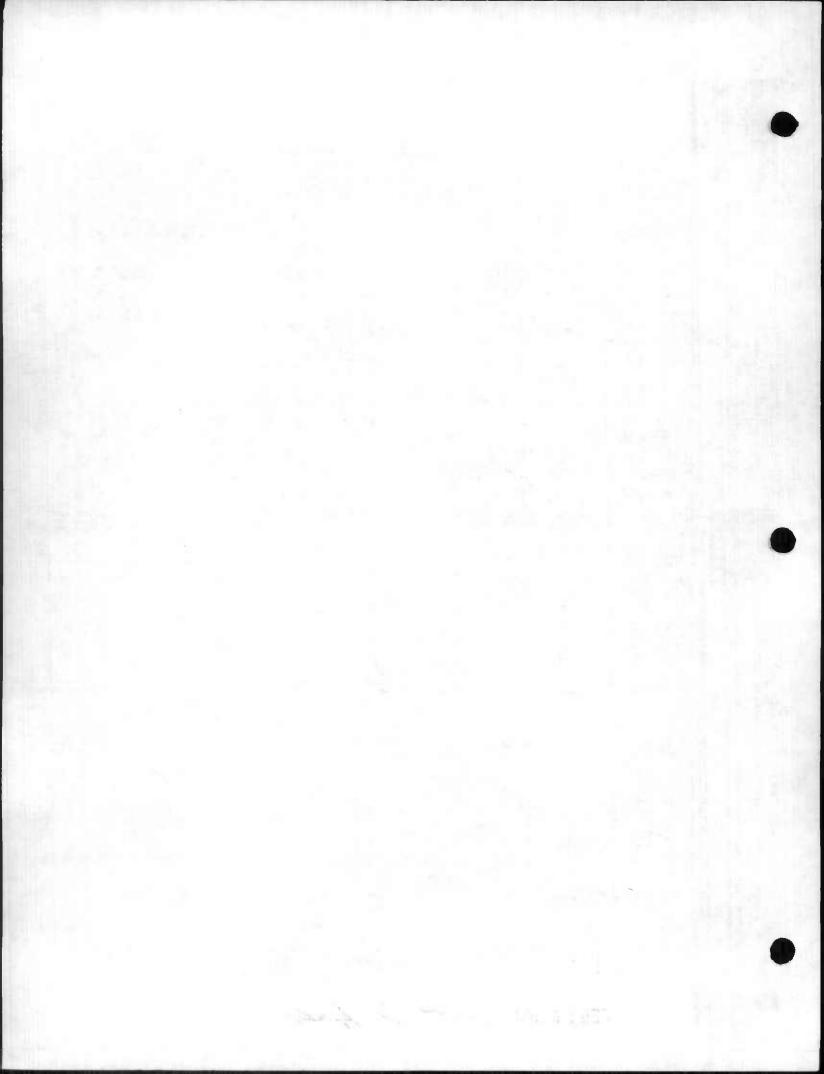
30. Nama and address of person who completed cause of deeth (ttem 23a) (Type, Print) 2111 Hanord

State Registrar 31. Date filed (Month, Day, Year) FEB 2 9 2000

32. Registrar's Signeture

2 Rotter

To the Hosp within 24 hou To the Fune completely fi



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Esther Price Ward February 23, 2000 5:00 AM 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Manor Care Ruxton Towson Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdey) Birthplace (Stete or Foreign Country) Days Months Hours 1 ☐ M 2 🛱 F Yrs 219-10-9412 80 Aug. 21, 1919 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Harford Joppa 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2410 Old Joppa Road 21085 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes ZX No If Yes, Give Year or Detes: 1 ☐ Yes 2 ☐ No Specify 3€ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 12 Librarian Public Education 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) John Henry Price Martha (u/k)Amoss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1223 Robin Hood Circle, Baltimore, MD 21204 Nancy W. Cushman / Daughter 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete 1 X Buriel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Christian Cemetery 2-26-00 Joppa, Maryland 22. Name end Address of Fecility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or hear failure. List only one cause on each line. Immediate Cause (Final ackin Soms 6 Man The disease or condition resulting in death) Due to (or as a consequenca of): Due to (or as a consequenca of): Due to (or as a consequence of):

Physician /Medical **Examiner**

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certificate

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within 24 hours after death To the Funeral Director:, completely filled in by the

death.

Hospital

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Records, P.O.

Division of Vital or Attending Physician: **Physician**

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Funeral

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28a-f show

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Maryland

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traumatic event, the Medical Examiner must be nutified at

Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical

Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24e. Wes an autopsy 1 Yes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1□ Yes 2☑ No Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how Injury occurred Naturel 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier

31. Date filed (Month, Dey, Year) State Registrar FEB 2 5 2000

29b. Signature and title of cartifia

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) tentena 32. Registrar's Signature

29c. License number

1mrs MD 21237

29d. Date signed (Month, Day, Year)

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The transfer of the state of th

Wageley, Charles F Baltimore, Maryland 21215-0020 Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

PHYSICIAN

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NAME

To the Hoepital or within 24 hours aft To the Funeral DI completely filled in nes Registrar

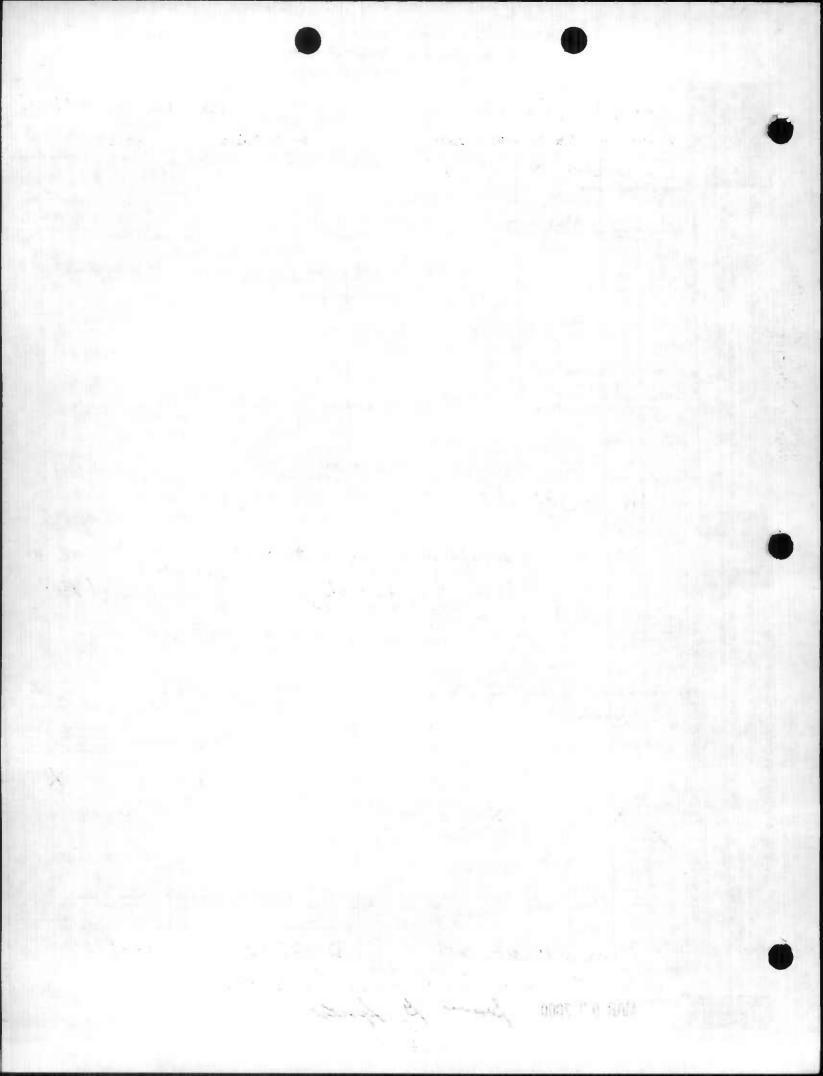
Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Mooth & Dey 22 Charles F. Wageley **Physician** 18:25 Wageley, Charles 00 /Medical 4a Facility Nemo (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner VA Maryland Health Care System Perry Point 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Day, Year) | Jan 5, 15 Cecil 6. Sex 1 M 2 □ F 5. Social Security Number 9. Birthplace (State or Foreign 215-20-6145 MD Director Usuet Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ? Is marked other than "naturel", or ferms 23s or 28s-f show treumstic event, the Moulds Examiner must be notified at Yes 2 No Allegany Cumberland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 811 Hicks Avenue 21502 USA Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
ATTYPES 2 No
If Yes, Give Yeer or Date Korean Was Decedent of Hispenic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Mantel Status Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes Z☐ No Specify: Specify: white by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retired PPG Industries 18. Mother's Neme (First, Middle, Melden Sumame) 17. Father's Name (First, Middle, Last) Henry Turner Wageley (Weimer) Mabel 19a, Informant's Name/Relationship (Type, Print)
Mildred A. Wageley 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 811 Hicks Avenue; Cumberland, MD 21502 Wife

20a. Method of Disposition

12 Burlal 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete Hillcrest Memorial Par2/26/ Cumberland, MD 21. Signature of Funeral/Servica Licansee Scarperii Funeral Home P.A. Cumberland, Maryland 21502 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examine Dementra physician and s the burlal-transil that the death certificate be axecuted Sequentially list conditions, if any, teading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): signed by the a 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown None p 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy Completed director, page 2 s al or Attending Physician: T s after death. Il Director: After this certificat od in by the funeral director, p 25. Wes case reterred to medical exeminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 □ ER/Outpatient 3 □ DOA Certification: To 27. Manner of Death
1 Natural
2 Accident 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 Could not be determined 28e. Piece of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

| Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartifier 2/22/00 D48215 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wark D. Heuser, Baltimore 10 North Greene Street 32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month **Physician** BERNARD BEPLER WADE 25, 2000 1:21 AM **FEBRUARY** /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ALLEGANY SACRED HEART HOSPITAL CUMBERLAND If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) 9. Birthplece (State or Foreign **Funeral** Deys Hours Yrs 92 214 07 6081 NOV 15 1907 MARYLAND Director Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits natural, or hams 23s or 28s-f sho edical Examinar must be notified at Yas 2 No Directo MARYLAND ALLEGANY FROSTBURG 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 171 E. MAIN STREET 21532 U.S. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Marital Status 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: à 3√ Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 10 MACHINIST CELANESE TEXTILE 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be should be is marked CLARENCE WADE LAVENIA DENNISON Department of Health and Important: If Item 27 is me any Injury or 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) PEGGY JEAN SLOAN / DAUGHTER 15023 ILLINOIS ROAD, WOODBRIDGE, VA 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) FROSTBURG MEMORIAL PARK 2/28/00 FROSTBURG, MD 22. Name end Address of Facility SOWERS FUNERAL HOME, P.A. 60 W. MAIN ST., FROSTBURG, MD 21532 or companions that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, the only one cause on each line. Approximate Interval Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examin sician and burief-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events signed by the attending physician be detached for use as the burle Box 68760 Physician/Medical Cardio Vascular Disease Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Failure 1 Yes 2 No 3 Probably 4 Unknown due Division of Vital Records, by 24b. Were autopsy tindings available prior to completion of cause of death? Wes an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case re 26. Piece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 1 petient 2 ER/Outpetient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred Certification: 1 Meturel 5 Pending investigation Injury death. 1 Yes 2 No 2 Accident Director: 3 Suicide 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) or A after 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. Medical 29a. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and little of certifie 3 FACP D13601 My FEBRUARY 25 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) Bishop Walsh Rd. Cumberland, MD 21502 925 nes FEL 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State MAR 0 1 2000 Registrar

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State of Maryland / Department of Health and Mental Hygiene

Physic	cian	1. Decedent's Neme (First, Middle, Last)		To be	PVS				2. Date of De Month	elh Dey	Yeer	3. Time of Death
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10	00	30 Name/and address	s of person who co	ompleted cause of	death (He	50+0/	Print)	ivo	Cum	201	and	MN	1-	1
-	tate	John Me	hanna Minipari)	74.0	902 strer's Sign	Setor	NY	ive	. Cumt	perl	and	MD	919	205

DHMH 16 Rev 6/95

The state of march 186 115 977

Box 68760. Records. Division of Vital **Physician**

/Medical

Examiner

5. Sociel Security Number **Funeral** Director 220 38 0691 Usuel Residence of Decedent with the Maryland 10a State 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at MD Director 10e. Street and Number 1 Baltimore Street Funeral 1 Never Married 2 Married 3altimore, Maryland 21215-0020 Àq 3 □ Widowed 4 □ Divorced Completed permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If fem 27 is marked other than eny Injury or other traument. Elementary/Secondary (0-12) 17. Father's Neme (First, Middle, Last) Be William (mnu) Long 0 19e. Informent's Neme/Raletionship (Type, Print) Royden W. Weimer /Son 20a. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 23a. Part1. Enter the disease, or/complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrast, shock, or haert failura. List only one cause on each line. **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in death) Examiner attending physician and for use as the bunial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In deeth) Last Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. been signed by the should be detached à Completed certificate 25. Was case raterred to medical axaminar? Be 1 Yes 2 No 2 this funeral 27. Menne of Death Certification: To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funera After 1 Naturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida 1 Cortifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mennar stetad. edicai 29a. Cartifier 29d. Date signed (Month, Day, Year) Z 29c. License numbe 29b. Signatury and title of pent of person who completed cause of death (Item 23a) (Type, Print) Terry Williams, M.D., Memorial Hospital Medical Bldg., Cumberland, MD 21502 nus 32. Registrar's Signalure FEB 2 2 2000

State Registrar

JAME 18 333

68760 Box 219-14-5781

Vital

P.O. Attanding 8 Physician

/Medical

Examiner

Funeral

Director

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Peges 1 and 2 should be nent of Health end Mental

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/Medical Examiner

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Physician/Medical

Completed by

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Certification: To

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death with the Maryland

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21215-0020

Baltimore, Maryland

Wilbur Weimer Division of

13 Nobs State Registrar

25. Was case referred to medical exeminer? 1 Yes 22No 27. Menner of Death 5 Pending 1 Netural 1 ☐ Yes 2 ☐ No Invastigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

February 20, 2000 D0054426

ue wo 30. Name end address of person who con of duals (Item 23a) (Type, Print)

500 Memorial Avenue, Cumberland, MD 21502 ding Zang Medical

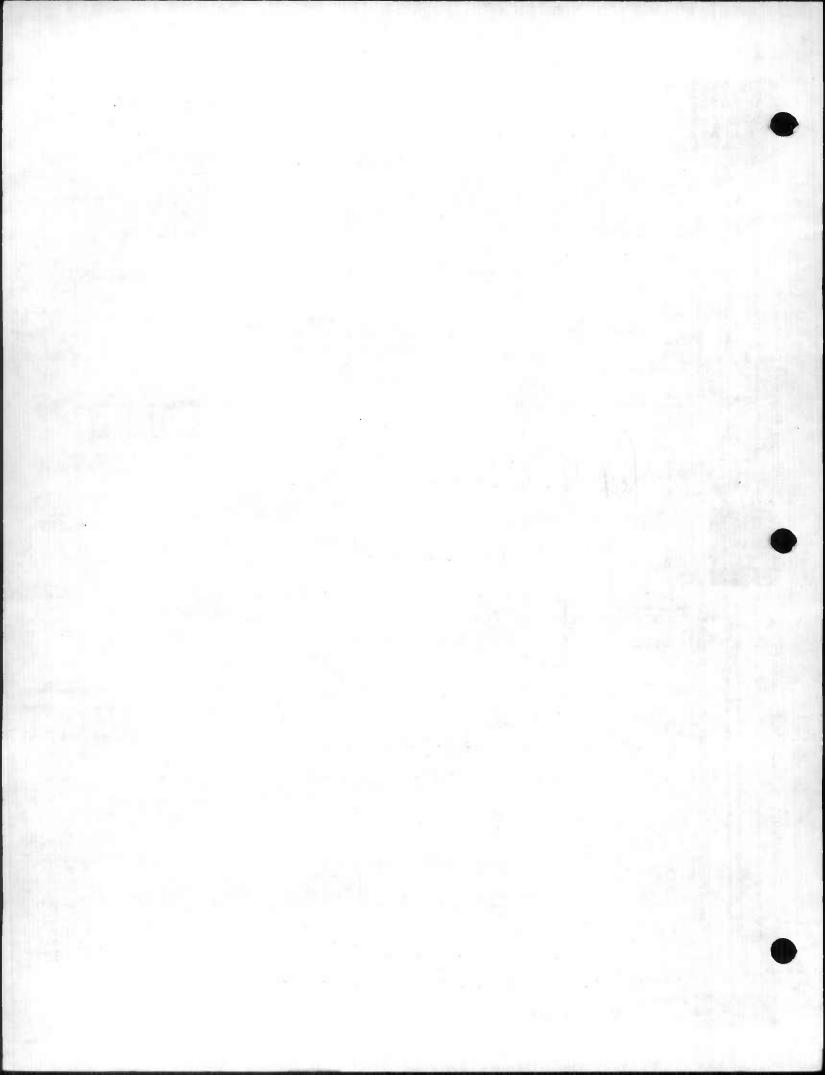
82. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 2 2 2000

Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	AMEND ITEM	1S: #8 PER F.H. G781 3-2	State of Maryla 23-2000 WR.		rtment of F			giene Reg. No.	0.8	504.		
	Physician /Medical	Decedent's Name (First, Middle, Last) RUTH	OVERTON	WH	ITED			ry 29,20	000	3. Time of Death 9:15AM		
	Examiner	4a Facility Name (If not institution, give s Civista Medical C				ib. City, Town, or La Plat	Location of Death	4c. County Char				
	Funeral Director	403-10 4323	7. Age (In yr 83	rs. last birthday) Yrs.	Months Days		8. Data of Birth (Month, Day Sept. 3	SEPT. 2 ,1916		rthplace (State or Foreign country) NNESSEE		
	death with the Maryland ma 23e or 28e-f show mast be notified at heral Director	Usual Residence of Decedent 10a. State 10b. County Maryland Prince G		10d. Inside City Limits 1 ☐ Yes 2 No								
	er death with the M thems 23e or 28e-f ner must be notific furneral Director	10e. Street and Number 4110 Farmer Place	10g. Citizen of W		ry?							
020	72 hours after death vine 234 files! Examiner must sted by Funeral	11. Marital Status 1 Never Married 2 Married 3 N Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	11	Vas Decedeni of H Yes, specify Cube	lispanic Origin? (an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		- America k, White, e			
Maryland 21215-0020	ed within 72 ho typens. Ner then "nehum it, the Medical J Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		16a. Deced (Give I life. D	kind of work done O NOT use retired	I's Usual Occupation d of work done during most of working NOT use retired)			16b. Kind of Business/Industry U.S. Governme			
land ;	Mental Hyg Mental Hyg Inhad other Ide event, To Be C.	17. Father's Name (First, Middle, Last) Henley F. Overton	23 THE	1	ou.i.y	18. Mother's Na Nona E	me (First, Middle, ffary	Maiden Sumam	e)			
Mary	nd 2 sho lift and h 27 is ma r trauma	19a. Informant's Name/Relationship (Ty) Edward Lee Overton					Waldorf,			Code) 0601		
nore,	antol Heam t: If Nam? y or other	20a. Method of Disposition 1 M Burial Cremation 3 R 4 Donator 5 Other (Specify)	amoval from Selbe	. Place of Dispos cemetery, crem	sition (Name of latory or other place	ce)	Date	20c. Location -	City or Tov	wn, State Virginia		
Baltimor	Department of the same injury	21. Sign and Arrived Service Company	Siplain	7 22 T	Name and Addre	ss of Facility Funeral	Home, I	nc.				
	Physician	23a. Part1. Enter the disease, or complice shock, or heart lailure. List only on	cations that caused the de e cause on each line.	ealh. Do not enta	r tha mode of dyir	ig, such as cardio	ac or raspiratory ar	rest,		Approximata Interval Between Onset and Death		
	/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	PNEC	(or as a consequence		,			1	-2 WEGK		
	m end in-transit	0.										
8760,	nysicie he bur	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
Box 6	5 G . P	L										
.O.	e deeth the ethe hed for Alcia	Part II. Other significant conditions conf	ributing to death but not re	esulting in the un	derlying cause giv	en in Part I.	23b. Did 1	23b. Did tobacco use contribute to the cause				
۵.	s that the product of	CONGESTIL	E HEA	4RT	4A1	URE	10	Yes 2□ No	3□ Prob	ably 4 Striknown		
of Vital Records,	The lew requires that the death certific site has been signed by the ettending p. page 2 should be deteched for use se Completed by Physician/Me	CEREBROV	ASCULA	RA	ccib	ENT	24a. Was perfo	an autopsy med?	ava	re autopsy lindings illable prior to npletion of cause leath?		
al R	yelclen: The lev is certificate has director, page 2 To Be Comp	CORONARY	ARTE	RY	DISE	DE.	101	1	1□	Yes 2□ No		
Ţ.	Physicien: ribis certific oral director, TO Be (25. Was case referred to medical aximiner?	ospital: 1 Appatient 2	ER/Outpatient	3□ DOA Oth	or	eath (Check only of Home 5 ☐ Resid		er (Specity)		
	Attending Physical Attention of the funeral iffication:	27. Manner of Death 1 Statural 5 Pending 2 Accident Investigation	28a. Data of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe I	now injury occurr	ed			
Division	tal or Attending P in after deeth. el Director: After tied in by the funer: Certification:	3 Suicide 6 Could not be 4 Homicide detarmined	28a. Place of Injury - At building, etc. (Spec		et, factory, office		28f. Location (S City or Tow	Street and Numb yn, State)	er or Rurai	Route Number,		
	To the Mospital or Attending Physics 24 hours effected. After this completely filled in by the funeral Medical Certification;	29a. Certifier (Check only one) 1 Certifying Physical Check only 2 Medical Examin	clan: To the best of my ki er: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at tha tir estigation, in my o	na, data and plac pinion, death occ	e, and due to the curred at the time,	cause(s) and ma data and place, a	nner as stand due to	ated the cause(s)		
	To the sound of th	29b. Signature and title of certifier	.1		29c. Licens			29d. Date signed	(Month, L	Day, Year)		
		30. Name and address of person who cor	npleted cause of death (Its	em 23a) (Type 1	D-444	36		163	20	1 2000		
		Ashvinkumar J. Pat	el,MD P.O. E	Box 1620		f,Maryla	nd 20604					
	State Registrar	31. Date filed (Month, Day, Year) MAR 0 2 20	32. Registrar's Sig	Mature &	Sport	2/						

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Ulysses William Wiles February 25, 2000 4:45 pm 4e Fecility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Mar 28, 1928 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1 M 2 F 216-22-8218 71 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick Frederick 1⊠Yes 2□No 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 2129 Wainwright Court, Apt 1-A 21702 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Comptroller of Treasury Revenue Collector 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Millard Wiles Clingan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 2129 Wainwright Court, 1-A, Frederick, MD 21702 Mrs Rosella H. Wiles/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 2 Burial 2 Cremation 3 Removel from Stete Mt Olivet Cemetery Feb 29,2000 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Keeney & Basford P.A. Funeral Home M00706 106 East Church Street, Frederick, MD 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Physician /Medical Examina and

Physician

/Medical

Examiner

Funeral

Director

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artment of Health octant: If Item 27 I

E/S

Baltimore, Maryland 21215-0020

Direct

Funeral

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Examiner Box 68760 Physician/Medical P.0. signed by Records, P Be Completed Vital certific Medicai Certification: To

25. Was case referred to medical 1 Yes

27. Menger of Death 1 Naturat 5 Pending investigation 2 Accident

6 Could not be determined 3 Suicide 4 Homicide

Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) Martifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated

(Check only one) 29b. Signeture and title of

29a. Certifier

29c. License number

D55518

ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

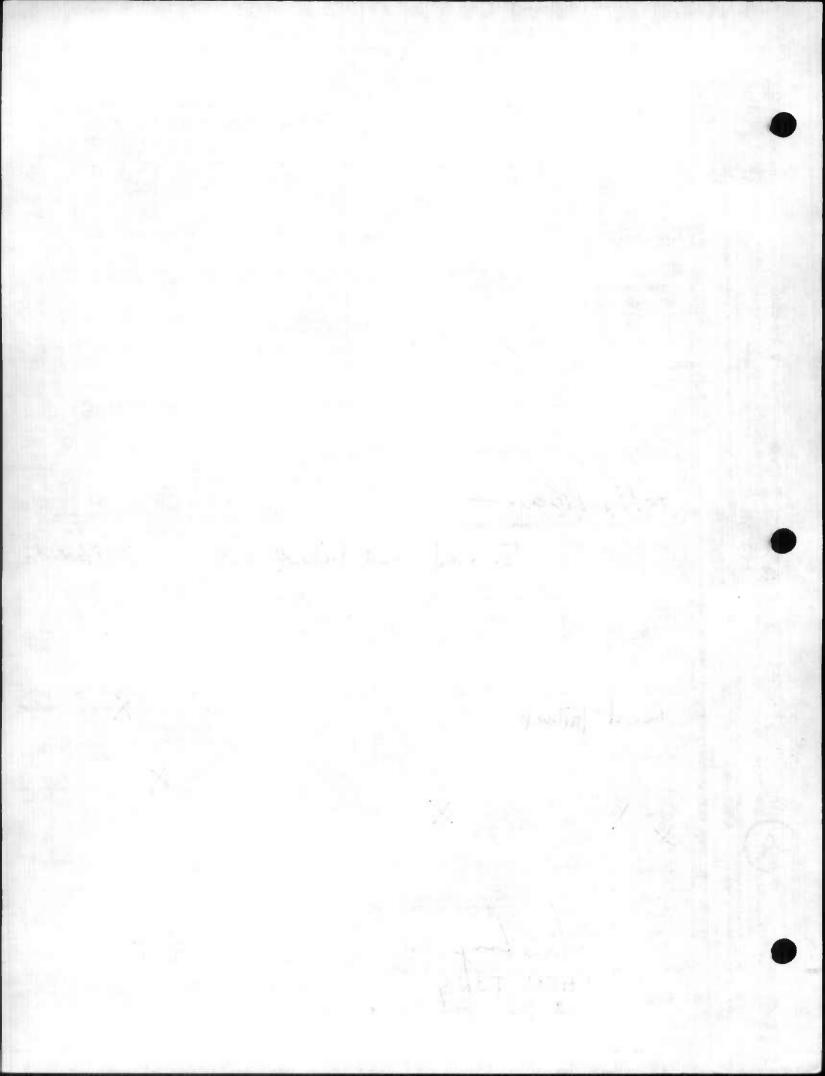
29d. Date signed (Month, Day, Year) 60

30. Name and address of person In (Item 23a) (Type, Print)

310 West Ninth Street, Frederick, Maryland 21701

State Registrar

To the Ha within 24 To the Fu



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month ROBERT February 0535 STAUNTON WALLIS 00 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Fallston General Hospital Fallston Harford 6. Sex 1 M 2 ☐ F If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Hours Yrs. 218-28-6773 69 Jan.9,1931 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zin Code 10o. Citizen of What Country? 604 Red Pump Road 21014 USA 12. Was Decedent Ever in U,S. Armed Forces? VI) Yes 2 Peace If Yes, Give Year or Dates: Time Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry State Transportation Elementary/Secondary (0-12) College (1-4or 5+) 12 Shop Clerk Authority 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Edison Lee Wallis Mary Byers Epperley 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 604 Red Pump Road, Bel Air, Maryland 21014 ce of Disposition (Name of Date 200. Location - City or Town, State Margaret E. Wallis- wife 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory or other place) Burial 2 Cremation 3 Removel from State Bel Air Memorial Gardens Feb. 24,2000 BelAir, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or fespiratory arrest. 1317 Cokesbury Road Abingdon, Maryland 21009 shock, or heart failure. List only only cause on each line. tntervel Between Onset and Deeth Immediate Cause (Finel disease or condition resulting in death) therogeleratic Cardiovascular disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 KiNatural 1 TYes 2 □ No

The law requires that the death certificate be executed Attending

Physician

/Medical

Examiner

Funeral

Director

28a-f

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Pages 1 and 2 ahould be filed within 72 hours after and of Health Hyplans. Institutely of the world file inverted other than "natural, or its inverted other than addoct Examination in or other traumatic event, the Medical Examination.

Physician

/Medical Examine

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21215-0020

Baltimore, Maryland

Division of Vital Records, certificate hes this funeral s efter deeth. filled in by 6 To the Hospital of within 24 hours of To the Funeral Dicompletely filled in

Medical Certification: To State

laRK 31. Date filed (Month, Day, Year) FEB 2 4 ZUUU Registrar

29b. Signature and title of certifier

2 Accident

4 Homicide

3 ☐ Suicide

29a. Certifier (Check only one) 6 Could not be determined

arty 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ILd

AVENUE BEL AIR Maryland 2 NORTH 32. Registrar's Signature Deneva

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

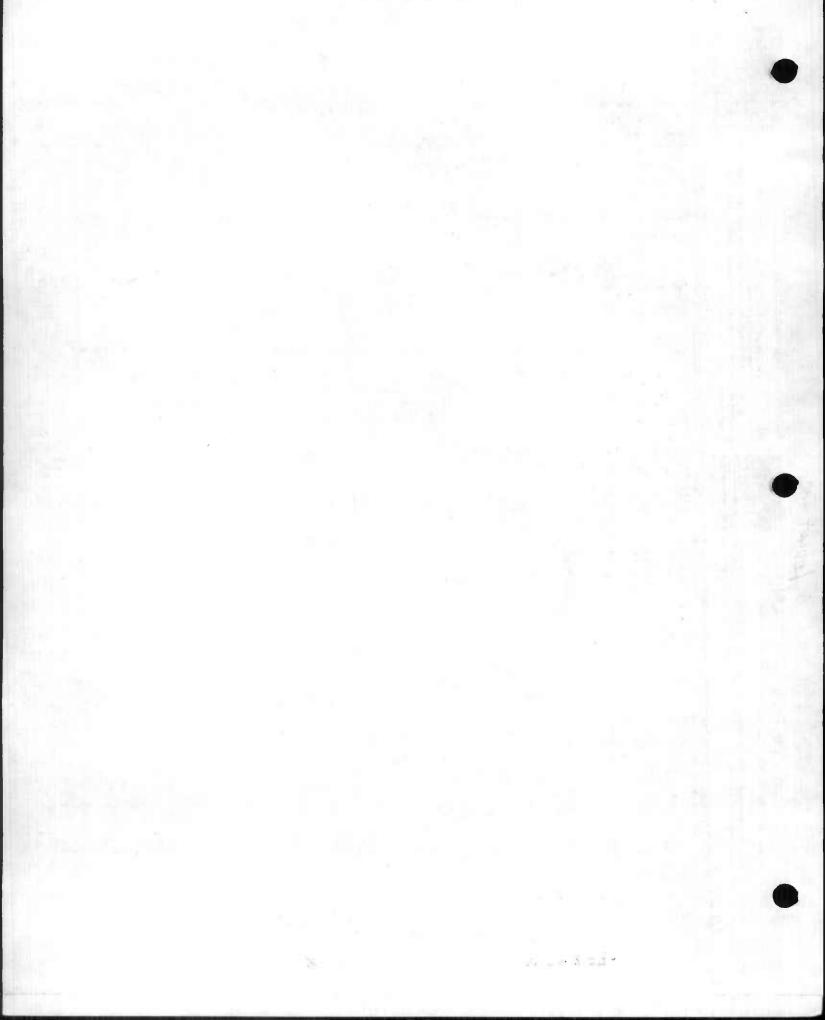
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted.

135522

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)



1 Decedent's Name (First Middle Lest)

Please Type or Print in Black indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

3. Time of Death 7:56 P.M.

ace (State or Foreign arolina

0d. Inside City Limits 1 ☐ Yes 20No

an Indien.

ite

r Code) 09 wn, State 7irginia

Approximate Interval Between Onset and Death

the cause of death? bebly 4 Unknown

24b, Were autopsy findings available prior to

completion of cause of death? 1 Yes 2 No

24a. Wes an autopsy performed?

1 Yes

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

2 No

GEDESTRAM STRUCK BY VAU

28f. Location (Street and Number or Rural Route Number, City or Town, State)

SINGER STESTCLAIR HARPORDGO, 410

29d. Date signed (Month, Day, Year)

February 16, 2000

	Physician /Medical	KIMBERLY MARGAI	RET WOLTZ					Februa:	ry 15,	2000 7		
	Examiner	4a Facility Neme (If not institution, gi Fa.llston Gener).			4b. City, Town, or L		4c. County	of Death ford		
	Funeral Director	5. Social Security Number 6. 241-37-9139	Sex 1□ M XXXF	e (In yrs. last bir	thday) If Under Months	Days		8. Date of Birth (Month, Day Jan . 11	Year) 1982	9. Birthplace N. Car		
7	2	Usual Residence of Decedent										
A CONTRACTOR OF THE CONTRACTOR	er show	Maryland Har:	ford	10c. City, Town	or Location bingdon					10d. In		
£	23a or 28a-fe	10e. Street and Number 2 Mitchell Drive	9			1009)	10	0g. Citizen of V USA	What Country?		
-0020	r, or he by Fu	11. Meritel Status 1 ②Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 Xi If Yes, Give Year or Detes:		13. Wes Dece If Yes, spe 1 Yes		Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)		es - American Ind ck, White, etc.		
3 (1)	natur. Detec	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a.	Decedent's Use (Give kind of w	iel Occu	pation during most of worl	king	16b. Kind of Br	usiness/Industry		
2121	or then	Elementary/Secondary (0-12)	College (1-4or 5	i+)			ol Student					
land	marked other marked other marke event, to To Be Co	17. Fether's Name (First, Middle, Las Alfred Huber					18. Mother's Nam	e (First, Middle, Met Sus		Taylor		
Mary	27 le ma r treuma	19a. Informent's Name/Reletionship Alfred H. Woltz					and Number or Ru					
Baltimore, Maryland	ertment of He ortant: if Nem Injury or othe	20a. Method of Disposition 1 Burial 2 □ Cremation 3 [4 □ Donetion 5 □ Other (Special Contents)			Disposition (Na y, cremetory or ston Nat			Date 2/23/00 F		city or Town, S		
Bait	Department Important: eny Injury poles.	21. Signature of Fundral Service Lice	me, P.A.	on, MD	21009							
	hysician /Medical	23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only on cause on each line.										
	xaminer	disease or condition resulting in death)	· Huun	Plu DI	y uning					1		
	i i			Due to (or as a	consequence of):						
60	sicien end burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or as a o	consequence of)	:	734					
Box 68760,	uby the ettending physicie etsched for use as the bur Physician/Medical	that initiated events resulting in death) Last	d	Due to (or es e c	onsequence of)					t		
	the ette hed for /sicia	Part II. Other significant conditions	contributing to death but	ut not resulting in	the underlying	cause g	iven in Part I.	23b. Did to	becco use co	ntribute to the		
. P.O.	ed by the detect of Phy							1 🗆 Ye	es 20 No	3 Probably		

Division of Vital Records Completed certificate Be edical Certification: To After this

OF

or Attending Physicien: The law require To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun

DHMH 16 Rev 6/95

MARAMON 31. Date filed (Month, Day, Year) State

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) A KOREU

MM 32 Registrer's Signeture

Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA

RODDWAY

28a. Dete of Injury (Month, Day Year)

2-15-00

28b. Time of Injury

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

19:03P M

111 Penn Street, Baltimore, Maryland 21201

28c. Injury et Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

O.C.M.E.

1 Yes 2 No

FEB 2 2 2000 Registrar

25. Was case referred to medical examiner?
1 Yes 2 No

29b. Signature and title of certifier

5 Pending investigation

6 Could not be determined

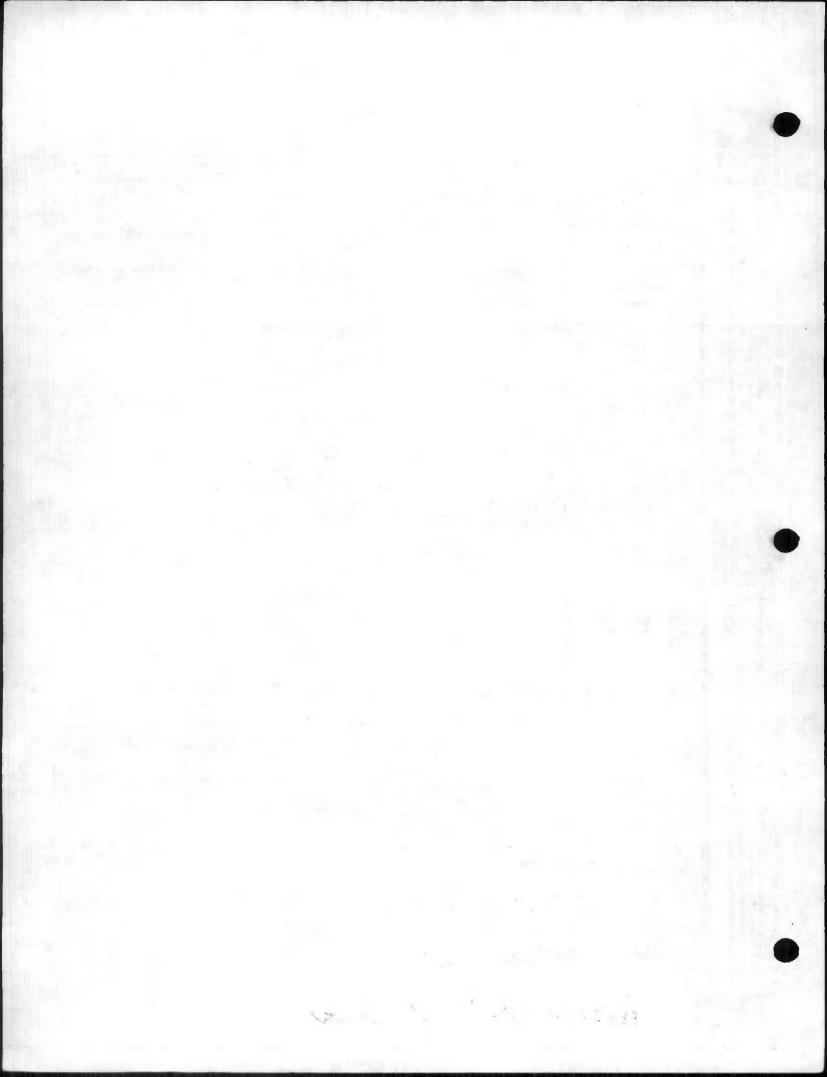
27. Manner of Death

1 Natural
2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Lest) 2. Dete of Death Month MARION WEST 4b. City, Town, or Location of Death 00 2000 4a. Facility Name (If not institution, give street end numbar) 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY if Under 24 Hrs. 8. WICOMICO If Undar 1 Year 5. Sociei Security Number 8. Date of Birth (Month, Dey, Year) Birthpleca (Steta or Foreign Country) 6. Sex 7. Age (In yrs. lest birthday) 1 M 2 □ F Days Hours Min. Yrs. 224-28-6057 4/17/1924 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inalde City Limits Maryland Worcester Pocomoke City 1 ☐ Yas 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2415 Old Snow Hill Rd. 21851 USA 12. Was Decedent Ever in U,S. Armed Forcas? 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: WW I 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indien, Black, White, etc. 1 Nevar Married Married 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced WW TT WHITE 15. Decedent's Education 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Auto Repair 17. Fathar's Name (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Charles West Lillie Gillespie 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Helen M. West/wife 2415 Old Snow Hill Rd., Pocomoke City, MD 21851 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Data 20c. Location - City or Town, State 1 Burial 2 Cramation 3 Removal from State First Baptist Cemetery 2/25/00 Pocomoke City, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funera Servica Licansee 22. Name and Address of Facility Holloway-Melson Funeral Home, P.A. mo1129 103 Linden Ave., Pocomoke City, MD 21851 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart fellure. List only one ceuse on each line. Approximete Interval Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in deeth) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE Due to (or es e consequenca of) Due to (or es a consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably XX Unknown 24b. Were autopsy findings avsileble prior to completion of causa of deeth? 24e. Was an autopsy performed? 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No 26. Plece of Deeth (Check only one)

Physician /Medicai **Examiner**

ettending physician for use es the burie

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certificate hes

After this

efter death.

within 24 hours e To the Funeral C Hospital

in by the

Be

2

Certification:

Medical

Attanding Physician:

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the

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medicai

Examiner

Funeral

Director

or 28a-f show

Herns 23a

6

"natural".

Pages 1 end 2 should be filed within nent of Health end Mental Hygiene. int: If Itam 27 is marked other than ' Irry or other traumatic event, the Me

permit. Page Department of Important: If any Injury or once.

Director

Funeral

þ

Completed

Be

2

traumatic event, the Medical Examiner must be notified at

the Maryland

72 hours efter

Baltimore, Maryland 21215-0020

Examiner Sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury thet Initiated events rasulting In death) Last Physician/Medicai by Completed

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

25. Was case referred to medical 1 Ves 2 No 27. Manner of Death 1 Natural
2 Accident 5 Pending Invastigation

1 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year)

28c. Injury at Work? 28b. Time of

28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

29e. Certifier

3 Suicide

4 Homicide

1 Certifying Phyalcien: To the best of my knowledge, death occurred at the time, date end plece, and due to the ceuse(s) and manner as steted.

Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the ceuse(s) and menner stated.

29b. Signature and title of certifian

29c. License number

29d. Data signed (Month, Day, Year)

Im 56 Suel le 30. Name and address of person who completed cause of each (Item 23a) (Type, Print)

6 Could not be determined

D0003599

106 MILFORD STREET

2-24-00

SALISBURY, MARYLAND

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

M.D.

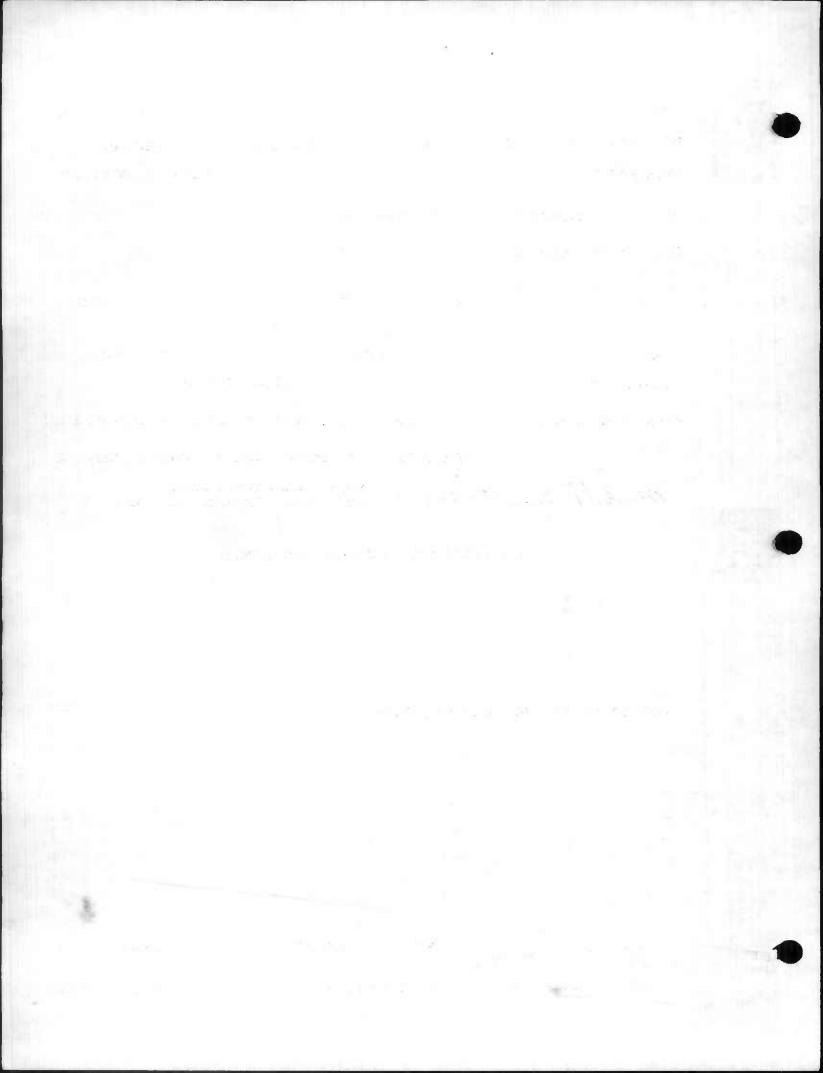
JOHN T. BULKELEY, 31. Date filed (Month, Dey, Yeer) State

32. Registrer's Signeture

Registrar

DHMH 16 Rev 6/95

21804

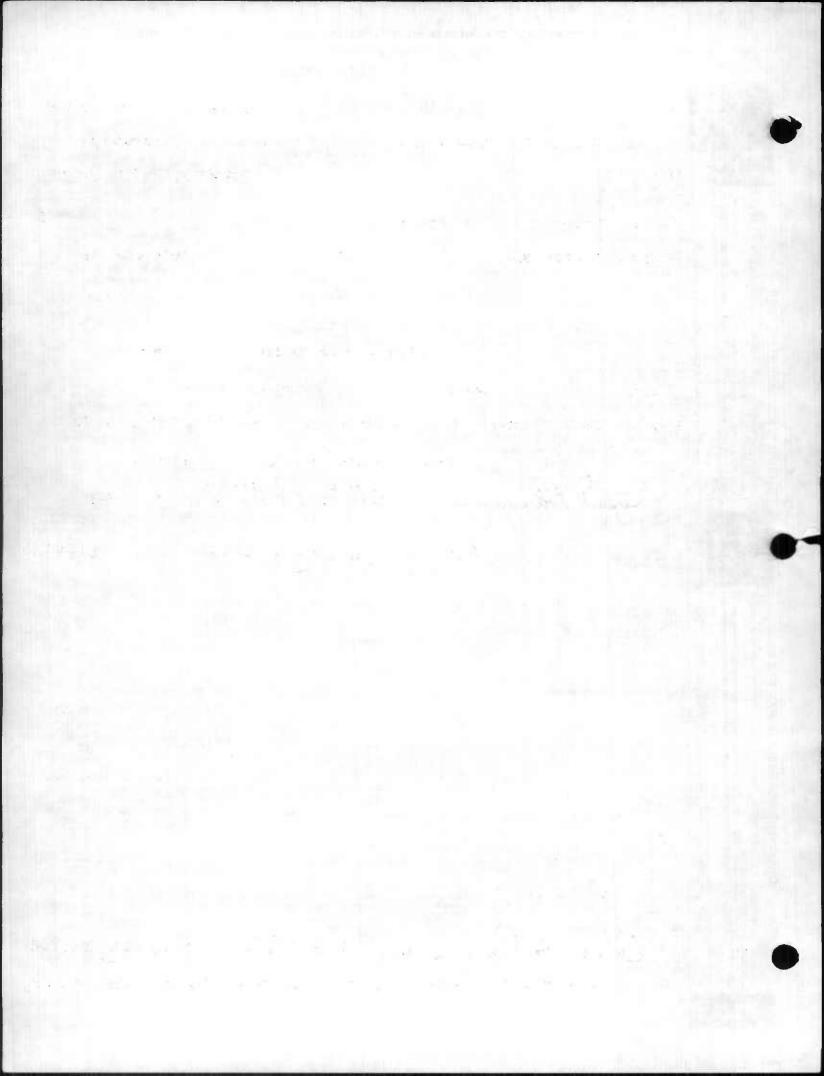


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate of	Death		Reg. No.	U	8589
		1. Decedent's Name (First, Middle	Last)			7.00		2. Data of D	eath Day	Year	3. Time of Deeth
Physici /Medic		Evelyn		Zabloc	ky			February		000	8:40AM
Examir		4a Facility Name (If not institution	give street and nu	mber)			4b. City, Tov	vn, or Location of Dea	th 4c. County	of Death	
		Montgomery Villa	0					ersburg	Montg	-	
Funeral Director		5. Sociel Security Number 578-24-8557 Usual Residence of Decedent	6. Sex 1 □ M 2 🗹 F	2 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 83 Yrs. Months Days Hours Min.					8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country) September 23, 1916 Pennsylvania		
land w		10a. State 10b. County		10c. Ci	ty, Town or L	ocation				1	0d. Inside City Limits
Mary	jo	Maryland Montgo	marv	Gai	thersb	uro					1 ☐ Yes 2 No
the 128	Director	10e. Street and Number	мету	Joan	CHCIOD	10f. Zip Code			10g. Citizen of N	What Coun	try?
3a o		19301 Watkins M	ill Road			20886			United	Stat	es
me 2	Funeral	11. Meritel Stetus	12. Was Dec	edenf Ever in U	,S. 13.	Was Decedent of I	tispanic Orig	oln? (Specify Yes or N		e - Americ	
72 hours after death with the Maryland natural, or items 23s or 28s-f show deat Examiner must be notified at	by	1 Never Merried 2 Marri 3 Widowed 4 Divorced	Armed Formation Armed Formation II Yes, Given or II	2 🖾 No		1 ☐ Yes 2 No		, Puerto Rican, etc.)	1111	ck, White, Whit	
"natural",	Completed	15. Decedent (Specify only highes	s Education		16e. Dece	dent's Usual Occup	pation during most	of working	16b. Kind of B	usiness/Inc	dustry
c = 41	nple	Elementery/Secondary (0-12)		1-4or 5+)		kind of work done DO NOT use retire					
filed within Hygiene. Ither than "	So	12			Admin	nistrativ	1			rance	
	Be	17. Father's Name (First, Middle, I	ast)				18. Mothe	r's Name (First, Middle	a, Maiden Suman	10)	
	2	Anthony		Zablock	1		Loui				
. a		19a. Informent's Name/Reletionsh	ip (Type, Print)					or Rural Route Num			
= 0 =		Rosella O'Toole	(Sister				chard	Road, Silv			20905
if item or othe		20a. Method of Disposition	3 □Removal from		Place of Disposeme <i>tery, cre</i>	osition (Neme of matory or other pla	ce)	March	20c. Location -	City or To	wn, State
ant: I		4 □ Donation 5 □ Other (Sp						nc. 1, 2000			MD
Department of H Important: If its any injury or ot once.		21. Signature of Funeral Stervice I	OD)		R	2. Name and Address app. Funer Febhen D.	al and Lohri	d Cremation mann P.A. ilver Spri	n Servic	es 209	10
		23a. Part1. Enter the disease, or shock, or heart feilure. List	complications that	caused the dea	th. Do not en	iter the mode of dyi	ng, such es	cardiac or respiretory	errest,	1	Approximete Interval Between
hysician /Medical		Immediate Cause (Final	orny one cause on	N				DICRASE		1	Onset and Death
Examiner	er	disease or condition resulting in deeth)	0		or es a conse	1	1				•
icate be axecuted physician and s the burial-transit	Examiner										
5 0 6	Medical										
attendir			d								
o dea	SIC	Part II. Other significant conditio	na confributing to d	leath but not res	sulting In the	underlying cause gi	ven in Part I.	23b. Die	tobacco use co	ntributa to	the cause of death
igned by the a	Physician/							10	Yes 2□ No	3 Prol	bably 4 Unknow
be d	by									Т	
been si	Completed							24a. Wa	s an autopsy formed?	av	ere eutopsy findings allable prior to
ata has by paga 2 st	ple									of	mpletion of cause deeth?
ata he paga	NO.							10	Yes 2 No	1[Yes 2⊠No
certificata rector, pag	Be (25. Was case referred to medical exeminer?			1		26. Place	of Death (Check only	one)		
O S	2	1 ☐ Yes 2 No	Hospitel: 1	Inpatient 2	ER/Outpatie	ent 3 DOA	her: 4 Nu	rsing Home 5 Res	sidence 6 🗆 Ott	ner (Specif	v)
Attending Physicien: st death. ector: After this certific by the funeral director.		27. Menner of Deeth 1 Netural 5 Pending 2 Accident investig		of Injury oth, Dey Year)	28b. Time of Injury	Wo	ryat rk? }Yes 2⊡!		how injury occur	red	
afor Atte	Certification:	3 Sulcide 6 Could r 4 Homicide determi	ned 288. Place	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					(Street and Numi own, State)	ber or Rura	I Route Number,
To the Hospital or Attending Pt within 24 hours attendeath. To the Funeral Director: After th completely filled in by the funeral	edical		xaminer: On the b					d place, end due to the			
vithin o th	Me	29b. Signature and title of certifier				29c. Licens	se number		29d. Date signe	d (Month,	Day, Year)
12		· Galval	AIS	arl	. M		306	35	Febru	say	29,2000
		30. Name and address of person v					Des 1	C., 4 + - 201	n1	111.	M4 2005
		Gabriel A. Be:	1	Registrar's Sign		dy Grove	koad,	Suite 305	, KOCKV	гтте	, Md. 2005
Sta Registr	_		2000 2	- Constitution of the	4	Sporks	/				
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DHMH 16 Rev 6/95



Physician	1. Decedent's Name (Fin	st, Middle, Last)	1- 00	711 10	10	,	2. Data of Dea Month	Day		Tim f th
/Medical Examiner	to Facility Name (15 and	CSS /		THUR	JK	4b. City, Town, or				4:38AN
LAGITITIE	Bon	1951	MIR			BA 271	MORE	n	1/A	
Funeral Director	5. Social Security Number 220-80-35	54 10	M 2□ F 7. Age (In yr	s. last birthday) If Ur Yrs. Mont	hs Days	If Undar 24 Hrs Hours Min.	8. Date of Birth Month, Day	1944	9. Birthplace	(State or Foreign
within 72 hours after death with the Maryland she. Bean "natural", or items 23a or 28a-f show he Madical Examiner must be notified at mojeted by Funeral Director	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Ins									
be notified at	MZ	NIA		BALTIM	ORD_				1	PYes 2□No
0 2 0		11/9	301 Time	10f.	Zip Code	1113		10g. Citizen of W	/hat Country?	
r items 23a	11. Marital Status	00 2 1	2. Was Decedent Ever in Armed Forces?	U,S. 13. Was De	ecedent of H	lispanic Origin? (S an, Maxican, Puer	pecify Yas or No-	14. Race	- Amarican In	dian,
by by	3 □ Widowad 4 □ [Married	Armed Forces? 1 ☐ Yas 2 ☑ No If Yes, Give Yaar or Dates;		specify Cuba s 2 No		o Rican, etc.)	Specify:	k, White, etc.	K
ner than "natural" t, the Medical Ex-	15. [(Specify on	Decedent's Educ ly highest grade	etion completed)	16e. Decedent's L (Give kind of	work done	during most of wo	rking	16b. Kind of Bu	siness/Industry	1
omo	Elementary/Secondary	(0-12)	College (1-4or 5+)	III DO NO	use retired	108		MITTERE	VH GR	RVICE
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other traumatic	19a. Informent'a Name/F	Relationship (Typ	en Print)	19b. Mailing Add	ess (Street	and Number or Ru	ral Route Number	r, City or Town,	State, Zip Code	11111
other tr	20a. Method of Disposition	47 /7	20b.	Place of Disposition (Neme of	Cours	Date	20c. Location - (City or Town, S	State
= 8 =	1 ☐ Burial 2 ☐ Cre 4 ☐ Donation 5 ☐		moval from State	Cemetery, crematory	noner piec	19)	3/13/10	Lars9	nunn	5 MD
pontant:	21. Signature of Furter of	Service License	11/	22. Nam	and Addre	79 519/19	CH Fun	5RA/ A	mEl	PA
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ial-transit		a b.	Resp	related	4.	Fall	elle			
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es the burial-transit		c.	Due to	(or as a consequence	STC)	at V.		ceny		
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deteched for use er			0	0						
5 E	Part II. Other significant	1 D C O R	Death but not re	esulting In the underlying	ig cause giv	ren In Part I.			tribute to the	4 Donknown
b b		TI COV	WC O	euse						
Completed							24a. Was a	an autopsy med?	24b. Were at available complet of death	utopsy findings e prior to ion of cause
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certificate has irector, page 2 Be Comp		medical		_		26. Place of Dea	ath (Check only o			223.10
ral dire	1 Yes 2 No	Ho	spital: 1 Illimpatient 2		DOA Oth	4 LI Nursing F	lome 5 ☐ Resid		1, 1, 1,	
funer funer tion:	27. Manner of Doeth 1 Naturel 5	Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 □ No	28d. Describe h	ow Injury occurre	ed	
led in by the funera Certification:	2 Accident 3 Suicide 6	Could not be determined	28e. Place of Injury - At building, etc. (Spec			163 2 110	28f. Location (S	treet and Numbe	er or Rural Rou	te Number,
ed in	4 Nomicide		building, etc. (Spec	city)			City or Tow	n, State)		
to the Funder Diffector: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	29e. Certifier (Check only 2 N	ertifying Physic fedical Examine	cian: To the best of my kr er: On the basis of examin	nowledge, death occurr netion and/or Investigat	ed at the tin	ne, dete and place plnion, death occu	, and due to the o	ause(s) end mer dete end place, a	ner as stated.	cause(s)
completely filled in by the fi	one) 29b. Signature and title of		end manner stated.		29c. Licens			29d. Date signed		
- 0	> AOZ	edd	Y M.D		D4	6305		3/9/	100	
	30. Name and address of	person who com	ipleted cause of death (Ite	em 23e) (Type, Print)	ANU	RADH,	ARE	DOY M	2.0	
	1940 WE	et 136	eltimore	Street	,030	altin	ole m	0218	223	
State	31. Date filed (Month, Day	r. Year)	32. Registrar's Sign	nature	,					

DHMH 16 Rav 6/95



State of Maryland / Department of Health and Mental Hygiene 08591 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** 2000 al Joseph Ataman 11 6:52 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore H Under 1 Year H Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. March 18 1936 Birthplace (State or Foreign Poland 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F 63 204-34-8068 YES Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Ves 2 No Director NA Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ð 238 5505 Hopkins Bayview Circle 21224 U.S. of America Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 Yes 2 No If Yas, Giva 1 Never Merried 2 ☐ Merried 8 1 Yes 2 No altimore, Maryland 21215-0020 Specify: White al Hygiene. Fother than "natural", o went, the Medical Exan þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Elamantery/Secondary (0-12) College (1-4or 5+) Librarian Library of Congress 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Pages 1 and 2 should be in timent of Health and Mental H tant: If Hem 27 is marked oil jury or other traumatic eves Be 2 Unknown Ataman Unknown 19a. Informant's Neme/Retetionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nadine Beckett (Guardian) 300 Metro Plaza Baltimore, Md. 21215 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method ol Disposition 20c. Location - City or Town, State March Burial 2 ☐ Cremetion 3 ☐ Removal Irom State Holy Rosary 4 ☐ Donetion 5 ☐ Other (Specify) 16 Dundalk, Maryland Name and Address of Facility
 Dabrowski-Chojnacki F.H.'s P.A. 21. Signeture of Funerel Service Lie 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dyng, such as cardiac or respiratory errest. 21224 Approximate triterval Between Onset and Death Physician /Medical Immediate Cause (Finel diseesa or condition rasulting in deeth) Pulmonary - Mucous Plug Hours Examiner Dua to (or as a consequence of): Pneumonia 1 Week The lew requires that the death certificete be axecuted Sequentially list conditions, if any, laading to immediate cause. Enter Undarlying Couse (Diseese or Injury that initiated events resulting in death) Lest pug burial-tran Due to (or as a consequence of): Subarachnoid Hemorrhage 4 Months Box 68760. Physician/Medical the Due to (or es a consequence of): USB signed by the at id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 | Yes 2 No 3 | Probably 4 | Unknown Records, þ 24b. Were autopsy tindings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? page 2 2 No 1□ Yes 1 ☐ Yes 2 ☐ No certificate of Vital or Attending Physician: director. 25. Wes casa referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient XI ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2√2 No this funeral 27. Manner of Death 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Pending 1 Netural after deeth. 1 TYes 2 □ No investigation 2 Accident 6 Could not ba 3 Suicide 28a. Ptace of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 4 Homicide filled in 24 hours a Funeral C Hospital **Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29e. Certifier completely (Check only one) To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH 13, 2000 D47479 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) BROCK BEAMER MD 5505 HOPKINS BAYWIEW CIRCLE BALTIMORE MO 31. Deta tiled (Month, Day, Year) 32. Registrer's Signetura State 2000 Registrar

this After deeth. after deeth Director: 2

Division of Vital or Attending Physician:

Completed Be To Certification:

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1/2 Yes 2 □ No 1₽ Ves 2□ No

March 04, 2000

25. Was casa retarred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: Other: Nursing Home 5 Residence 8 Other (Specify) Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Data of tnjury (Month, Day Year) 12-31-99 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury et Work? A 5 Pending investigation 12:29 1 Naturat SUBJECT WAS ASSAULTED 1 Yes 2 No M 2 Accident 6 Could not be determined 3 Suicide 4 Homicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Bural Route Number, City or Town, State) 1500 BLK. ELMTREE ST STREET BALTIMORE, MARYLAND 29a, Certifier

(Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred et the tima, deta and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

O.C.M.E.

wite mo

2000

29c. License number 29d. Date signed (Month, Day, Year)

ne and addrass of person who completed causa of death (Item 23a) (Type, Print) hutemo

111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signatura

State Registrar

DHMH 16 Rev 6/95

filled in

Medical

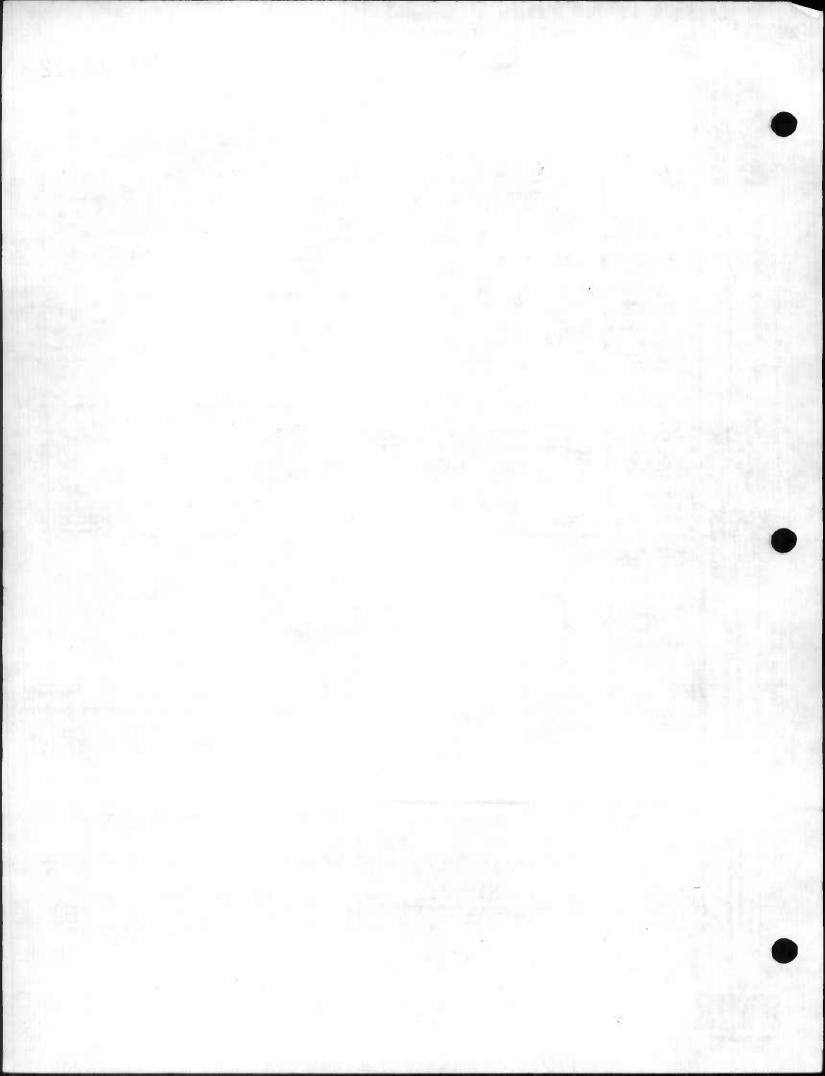
To the Hospital of within 24 hours of To the Funeral Discompletaly filled in

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31. Date filed (Month, Day, Year)

Lane



State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death march **Physician** CHARLES JAMES BOGERT 6:50 pm 2000 10 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin Square Hospital Center hosedale Baltimore Hours Min. 8. Date of Birth (Month, Day, July 2 If Under 1 Year 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10M 20 F 199-09-3144 Yrs **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f ahow other traumetic avent, the Medical Examiner must be notified at Md Baltimore Wilson Point 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 21220 1413 Fourth Road "natural", or items 23s Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2√2 No If Yes, Give Year or Dates: 1 ☐ Never Merried 25 Merried 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiens Important: If item 27 is marked other than in July or other transming in July 1988 Elementery/Secondary (0-12) College (1-4or 5+) Mechanical Maintence Beth Steel 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Stetler Bogert Mary McCullough 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Bogert / wife Baltimore 1413 Fourth Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State Metro Crematory Inc. 3/14/2000 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Connelly Funeral Home of Essex 23a. Part1. Enter the disease, or complications that caused the death De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Intervet Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . strone 30 minutes Examiner Due to (or as a consequence of): Physician/Medical Examiner Fibrillation 5years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or as e consequence of): 68760 c. Coronary Artery Disease

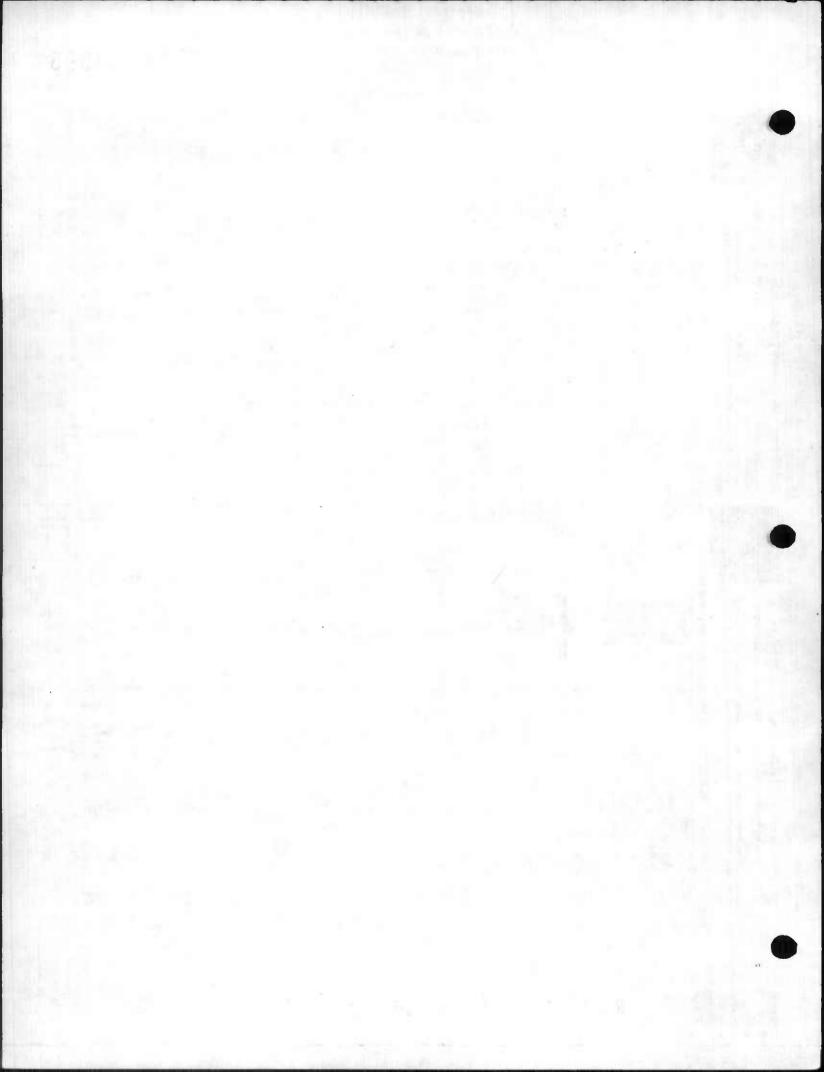
Due to for as a consequence of): 20 years the Box P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica stelly filled in by the funeral director, g Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital o within 24 hours all To the Funeral Di completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number William andrew Reme, MP Morch 12, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR William RENIE 9000 Franklin 9000 Franklin Square Orive Baltimore m.D. 21237

State Registrar 31. Date filed (Month Day, Year) MAR 1 5 2000 32. Registrar's Signature

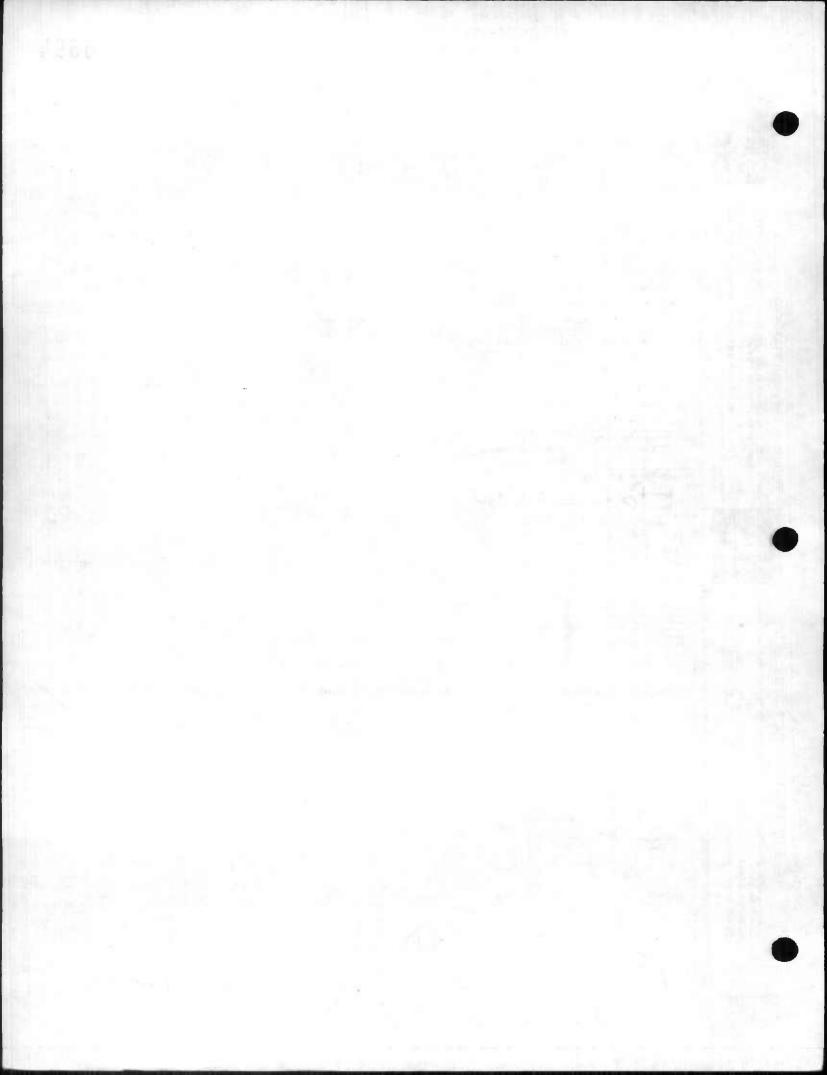
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State of Maryland / Department of Health and Mental Hygiene 00 08594

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AMEND II	EMS: #23 PA			EO G782	Ce	unicate	Or	Death	1	2. Date of Dea	th		3. Time of Death		
Physician /Medical	Montrell Isiah Brown									MARCH 13, 2000			11:36 AM		
Examiner	SINAI HOSPITAL BALTIMO							TIMO							
Funeral Director	5. Social Security Nun 213-57-15	Sex 1MM 2□ F				Months Days Hou			8. Date of Birth (Month, Day Dec 19	y, Year) 9. Birthplac Country Mai		ace (State or Foreign try) aryland			
f show led at	Usual Residence of D 10a. State 1 MD	Ob. County Ball	10c. City	10c. City, Town or Location Catonsville						10d. lr					
23e or 28e-f ast be notified al Director	10e. Street and Numb		110			10f. Zip (Code	21228		1		g. Citizen of What Country? USA			
by Funeral	11. Marital Status 12. Was Decedent Ev Armed Forces? 12. Was Decedent Ev Armed Forces? 1 Never Married 2 Married 13 Widowed 4 Divorced 14 Sq. Give Year or Dates:														
Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) infant					rking 16b. Kind of Business/Industr					
To Be C	17. Father's Name (First, Middle, Last) Bradford Brown Jr.										Maiden Sumam ell Jon				
, Maryland and 2 should be file sells and Mental Hy n 27 is marked other traumatic event.	19a. Informant's Nam Bradfo	e/Relationship rd Brow									e, Mary				
- A COL	20a. Method of Disposition 133 Burial 2 Cremation 3 Removal from Stal 4 Donation 5 Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery						20c. Location - City or Town, State Woodlawn, Marylan		wn, State		
ny inju	21. Signature of Funeral Survice Librosee				22. Name and Address of Facility Cap					ple Fun	ple Funeral Service				
I Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be deteched for use as the burial-transit Completed by Physician/Medical Examiner	resulting in death) Di Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				DDEN INFANT DEATH SYNDROME rue to (or as a consequence of): rue to (or as a consequence of): rue to (or as a consequence of):										
Physicia	Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause give						jiven in Part I. 23b. Did tobacco use contribute to t								
page 2 should be								performed? avail com of de		are autopsy findings hilable prior to impletion of cause death?					
After this certification funeral director tion: To Be	25. Was case referred to medical examiner? 1 ☑ Yes 2 ☐ No 1 ☑ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Yes) 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be				ear) 28b. Time of lnjury at Work? 1 □ Yes 2 □ No 28d. Describe how injury occurred						red				
ous after death. eral Director: After filled in by the fune il Certification	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Num City or Town, State)														
within 24 hours after deal To the Funeral Director: completely filled in by the Medical Certifical	(Check only ane) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to ane) 20 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to ane) 29c. License number 29d. Date signed (Month,								and due to	the cause(s)					
6 41	Putania				O.C.M.E.					MARCH 14, 2000					
State Registrar	30. Name and address	sep)	completed cause	of Jeath (Item	11:	Print)	St	9.5.			Mary.la				



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible. 0 8 5 9 5 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) Month 03 140 A **Physician** 09 BAILEY 2000 ABELLE /Medical 4a Facility Name (If not institution, give streat and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner IBRLY HOSPITAL KALTIMORE If Under 24 Hrs. 5. Social Security Number 7. Age (in yrs. last birthday) If Undar 1 Yaar Birthplace (State or Foreign Country) 6. Sex Days 1 M 2 KF Months Hours 68 Yrs. 213-30-329 Usual Residence of Decedent AND MAR Director the Marylend 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits from 27 fa marked other than "natural", or from 23a or 28a-f ahow other traumatic event, the Medical Examiner must be notified at 1.8 Yes 2 □ No Director ALTIMORE MARILLAND 10e. Street and Number 10g. Citizen of Whet Country? HOLLY STREET 1104 USA. Funeral 14. Race - Americen Indian, Black, White, etc. 12. Was Decedent Ever In U.S. Armed Forcas? 1 Yes 2 27 No If Yes, Give Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, etc.) 1 Never Married 2 Married Specify: BLACK Baltimore, Maryland 21215-0020 1 Yes 200No Specify b 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pemnit. Pages 1 end 2 should be filed within 7 Department of Health end Mental Hygiena. Important: if Nem 27 is marked other than "rangely Injury or other traumatic event, in the Modes. Elementary/Secondary (0-12) College (1-4or 5+) 12++GRADE TELE SERVICE REPRESENTATIVE SOCIAL SECURITY ADM 18. Mother's Name (First, Middle, Meiden Sumama) 17. Father's Name (First, Middla, Last) Be 10 MABELLE ANNETTE ROBINSON WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1104 MT. HOLLY ST. BALTIHORE, MD. 21229
ce of Disposition (Neme of Date 20c. Location - City or Town, Stata KENNETH R. BAILEY (HUSBAND) 20b. Place of Disposition (Neme of cematary, crematory or other plece) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State ARBUTUS CEMETERY 03-14-00 BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) Prior Funeral Service Licensee

22. Name and Address of Facility

3. Funeral Maryland

22. Name and Address of Facility

3. Funeral Maryland

4. Funeral Maryland

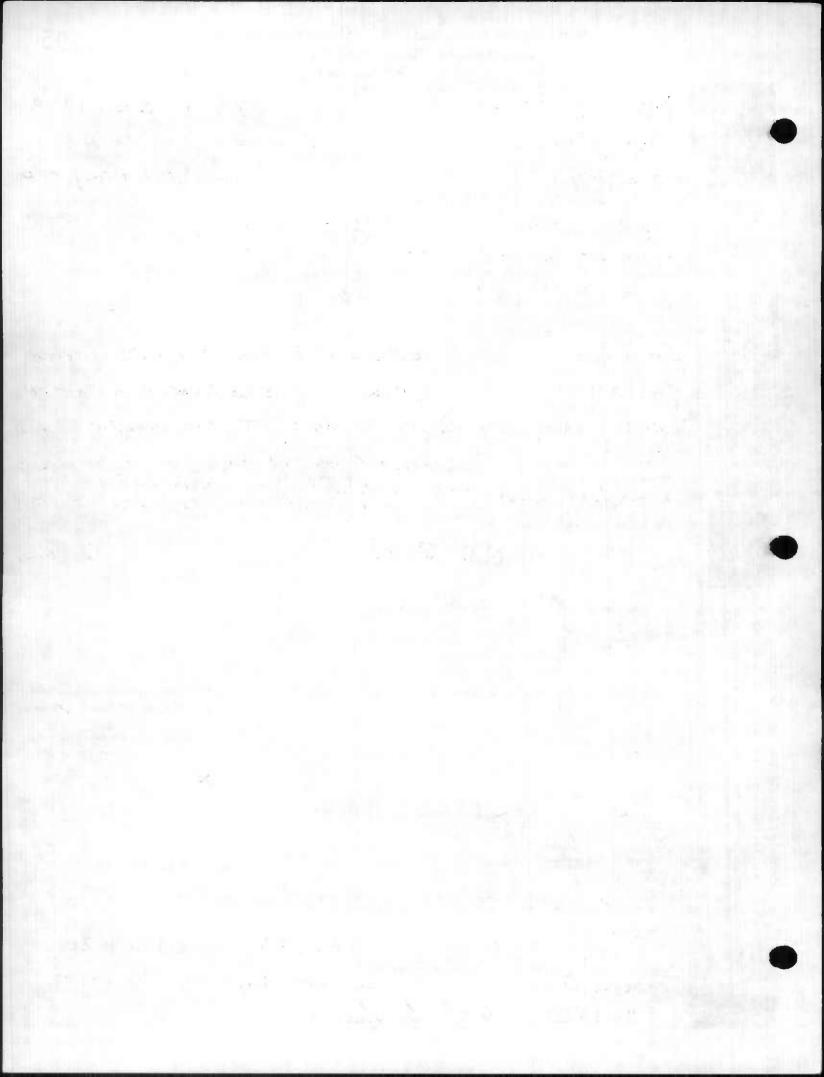
4. Funeral Maryland

5. Funeral Maryland

5. Funeral Maryland

5. Funeral Maryland

6. Funeral Mar 21. Signature of Funeral Service Licensee **Physician** Bleed /Medical Immediate Cause (Final 12 hours disease or condition resulting in death) **Examiner** Examiner Sequantially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or Injury that Initiated evants resulting in death) Last Due to (or as a consequence of) pue attending physician Physician/Medical the Dua to (or as a consequence of) as usa 23b. Did tobacco use contributa to the causa of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Division of Vital Records, P.O. the signed by t 1 Yes 2 No 3 Probably Munknown g 24b. Ware autopsy findings evelleble prior to completion of ceuse of death? Completed 24a. Was an autopsy Yes 2 | No 1 ☐ Yas 2 ☐ No certificate 25. Was cese referred to medicel axaminar? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 No 2 patient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Avatural 2 Accident or Attending 5 Panding after death. 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicida 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 24 hours a 15xCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medicai (Check only one) To the F 29d. Data signed (Month, Day, Year) 29b. Signeture and title of certifier 29c. License number Costs, Mo 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) PUALE BACTIMONE COSTA 301 ST PAUL SOSEPH 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 1 5 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Yea **Physician** WILLIAM BROOKS M 220 PM 0 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE VETERANS AFFAIRS HOSPITAL BALTIMORE BALTIMORE If Under 24 Hrs. 8. Date of Birth 6. Sex 1 M 2 F If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. lest birthdey) Months Days Hours 220-20-0163 Yrs. **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumetic svent, the Medical Examinar must be notified at Ves 2□No BALTIMORE CI Directo MARYLAND 10e. Street and Number 10g/Citizen of What Country? NNSYLVANIA AVENUE 21201 USA. 1100 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give Year or Dates: permit. Pagas 1 and 2 should be filed within 72 hours after dea.
Department of Haalth and Mental Hygiene.
Important: If them 27 is marked other than any injury or other traumout. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, atc. 1 Never Married 2 ☐ Married 1□ Yes 2KNo Specify: þ 3 Nidowed 4 □ Divorced BLACK Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) -ABORER FOUNDRY 12 HHGRADE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be BROOKS 2 DOROTHY WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) 320 N. SISTER) MONROE STREET, BALTI MORE, MD. 2/223
eme of Date 20c. Location - City or Town, State GERALDINE 20b. Place of Disposition (Name of cametery, cremetory or other placa) 20a. Method of Disposition 12 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23-16-00 OWINGS MILLS, MD. GARRISON FOREST 22. Name and Address of Facility JOSEPH H. BROWN JR. FUNERAL HOME 21. Signature of Fun ral Servica Licensee JOSEPH 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. FULTON AVE., BALTIHORE, MO. 2121 Approximate Interval Between Onset and Death **Physiclan** Immediate Cause (Final disease or condition resulting in death) /Medical ASPIRATION 4 HOURS Examiner Examine EREBROUASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 physician Physician/Medical 2 Due to (or as a consequence of): 23b. Did tobacco uss contribute to the causs of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 25 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) 1□ Yes 2√ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Anpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 28c. Injury et Work? 28e. Dete of Injury (Month, Day Year) Certification: 5 Pending Investigation 1 Netural 2 Accident 1 Tyes 2 No after death Director: 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 - Homicide To the Hospital within 24 hours a To the Funeral E e Hospital Medical 29a. Certifier 🗠 Csrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. 2 Madical Examiner: On the besis of exeminetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 386 MO

STREET, BALTIMORE, MO

State Registrar

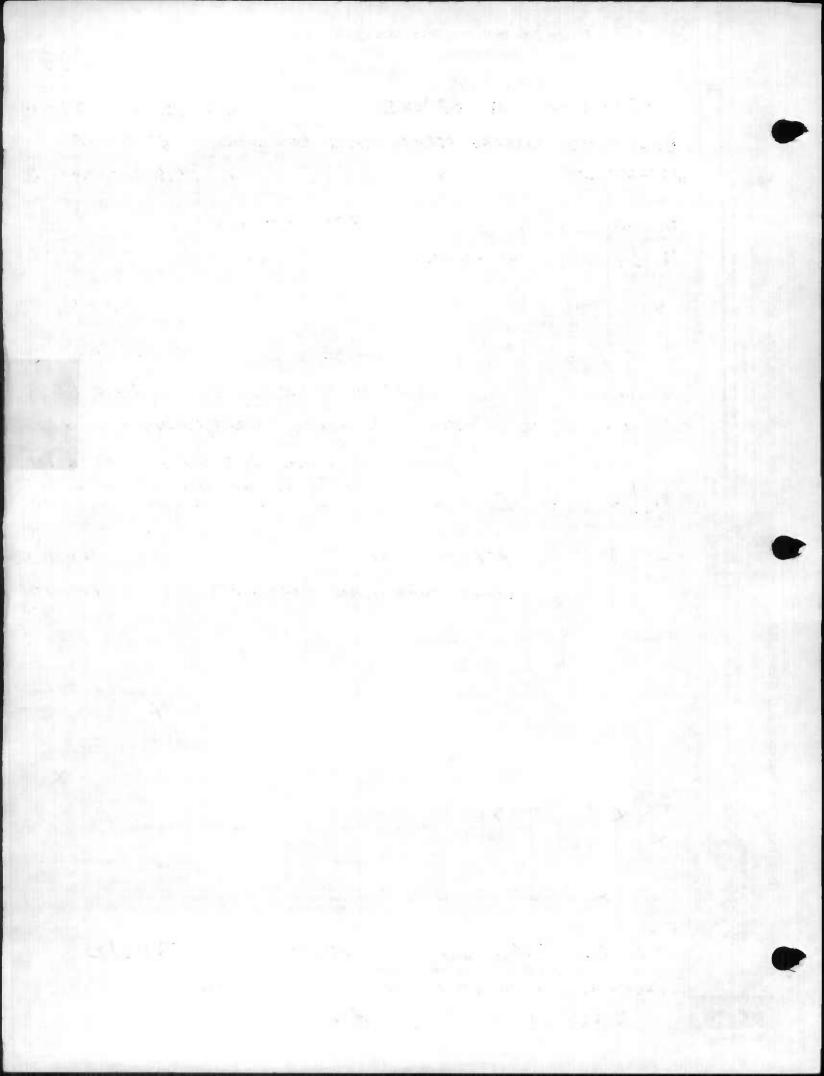
30. Name and eddress of person who completed cause ot death (Item 23e) (Type, Print)

SOUTH GREENE 32. Registrer's Signature

Upera

WILBUR KUO, 32 31. Date filed (Month, Dey, Year)

MAR 1 5 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1355h 13, Marjorie Blackburn 2000 Mar 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Howard County General Hospital Columbia Howard If Under 1 Year If Under 24 Hrs. 8, Date of Birth (Month, Dey, Year) 5. Sociei Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplece (State or Foreign Country) 1□M 2 F Yrs. Sept 10, 1918 81 279-10-1768 Ohio Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3004 N. Ridge Rd. APT 333 21043 United States 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3

Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Home Maker 12th Her Home 17. Father's Neme (First, Middle, Lest) 18. Mother's Name (First, Middle, Meiden Sumeme) Robert A. Donaldson Pearl Coe 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) David Blackburn (Son) 2570 Vance Dr. Mt. Airy, MD 21771 20a. Method of Disposition 20b. Placa of Disposition (Neme of cemetery, crematory or other plece) Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 3/14/00 County Sykesville mo. Cremations 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lips 22. Name and Address of Fecility Burrier-Queen Funeral Directors 1212 West Old Liberty Rd. Winfield, MD 21784 23a. PartT. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) whoridad Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last Due to (or as a sonsequence of): Due to (or es a consequence of): Dhageal Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? Coopliaged Blooding 1 Tee 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was en autopsy completion of cause of deeth? Astec Velve 1 Yes 2 1 No 1 Yes 2 No 25. Wes case referred to medical examiner? 28. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Natural

Physician /Medical Examiner

Examiner

Physician/Medicai

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Completed

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Certification:

edical

2 Accident

4 Homicide

3 ☐ Sulcide

29e. Certifier

Physician

/Medical

Examiner

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Funeral

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Funeral

Director

the Mervie

Maryland 21215-0020

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7 is marked other than "natural", or frams 23s or 28a-f show traumatic event, the Medical Examinat must be notified at

Pages 1 and 2 should be filed within 7 nent of Health and Mentel Hygiene. nt: If itam 27 is merked other than "I

other 1

Department of Important: If any Injury or 6

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funeral director, this

Division of Vital Records, P.O. Box 68760, after death.

Director: After 24 hours a within 2 To the

> State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated. 29b. Signature and

29c. License number

1 Yes 2 No

29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Route Number, City or Town, State)

cause of death (Item 23e) (Type, Print) 2620

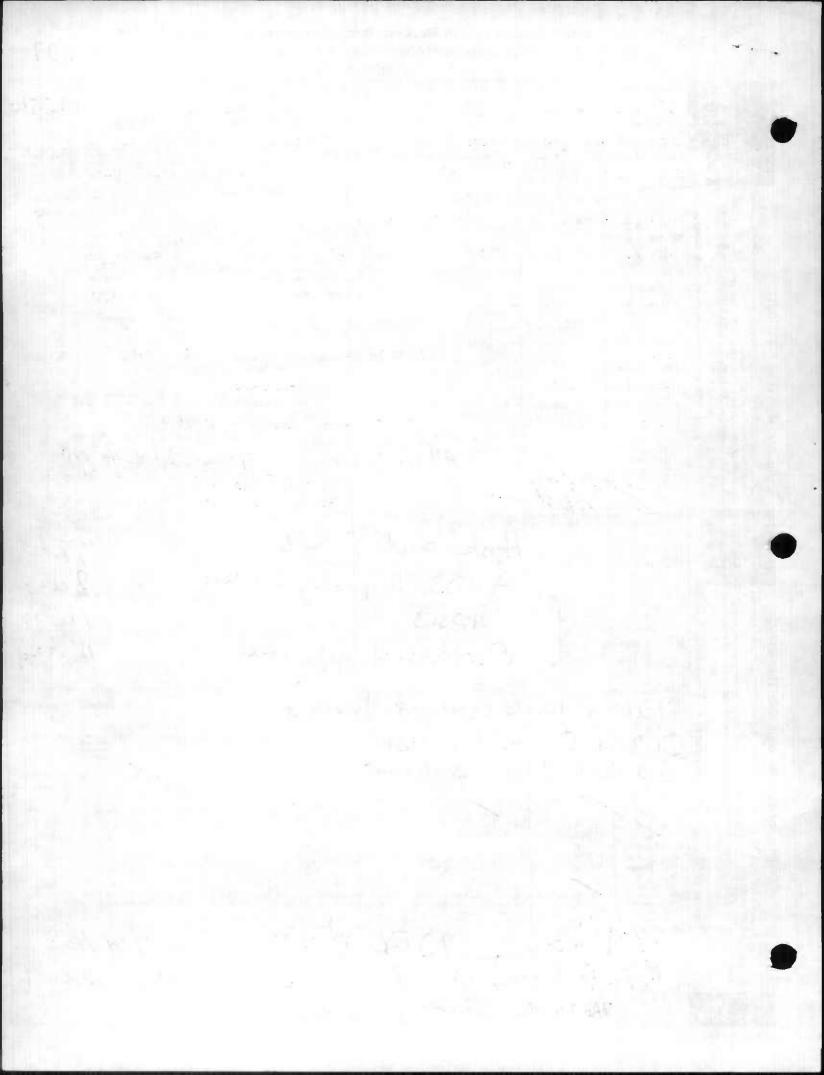
2000

6 Could not be determined

7360 32. Registar's Signature

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

Colecalia



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMENDED ITEM10b, 20b PER FH G781 3/15/2000 AH Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Year **Physician** Month 51 ther BaLon 4:51 AW 2500 march /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NORTHWEST HOSPITAL KANDALISTOWN If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03-27.43 # Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months 102M 20 F Yes 56 MO 098.32.6477 Director Usual Residence of Decedent 10b. County BALTIMORE 10c. City, Town or Location 10d. Inside City Limits 1 TYPE 2 NO MD GWYNN Director GWYNN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2205 WHEATLEY 21207 USA DRIVE Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: BLACK rland 21215-0020 1 ☐ Yes 2 Ø No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) STEAM HITER CONSTRUCTION 12 TH GRADE NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental BACON ARTHUR EDNA JACKSON 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) BACON 2701 BALTO ELSINORE mportant: If Item 27 iny injury or other to EDNA AVE MOTHER MD. 21216 altimore, 20b. Place of Disposition (Name of cametery, crematory or other place) CREMATORY Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 03.14.00 BALTO. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility CREMATION SERVICES 5151 BALTO NATL' PIKE, BALTO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or head failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ieredid vasinder **Examiner** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): 5x 68760 Physician/Medical Due to (or es a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed I Records, þ 24b. Were autopsy findings svailable prior to completion of cause of death? 24a. Was an autopsy Completed page 2 1 Yes 2 No 1 □ Yes 2 □ No certificate Division of Vital To the Hospital or Atlanding Physician: within 24 hours effer death.

To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Monpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29e. Certifier 29d, Date signed (Month, Day, Year)

0 State Registrar DHMH 16 Rev 6/95

29b. Signature and title of certifier

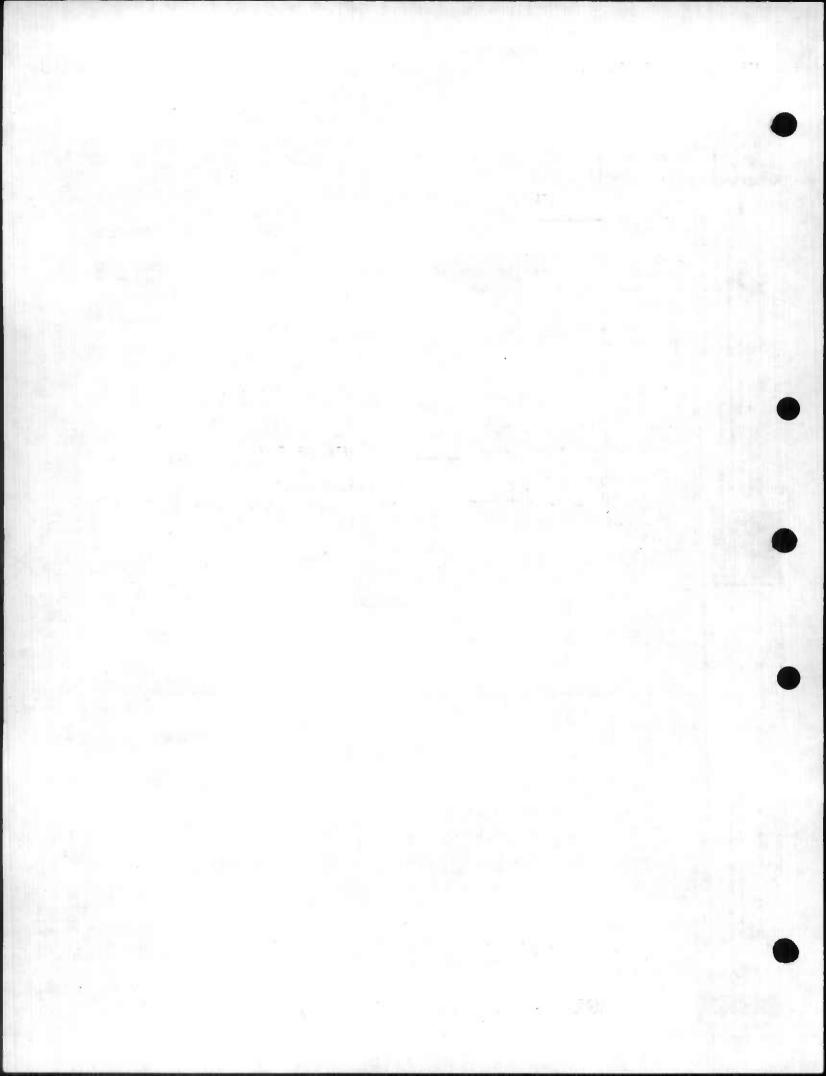
31. Date filed (Month, Dy (19)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

with

2000². Registrar Signature

29c. License number



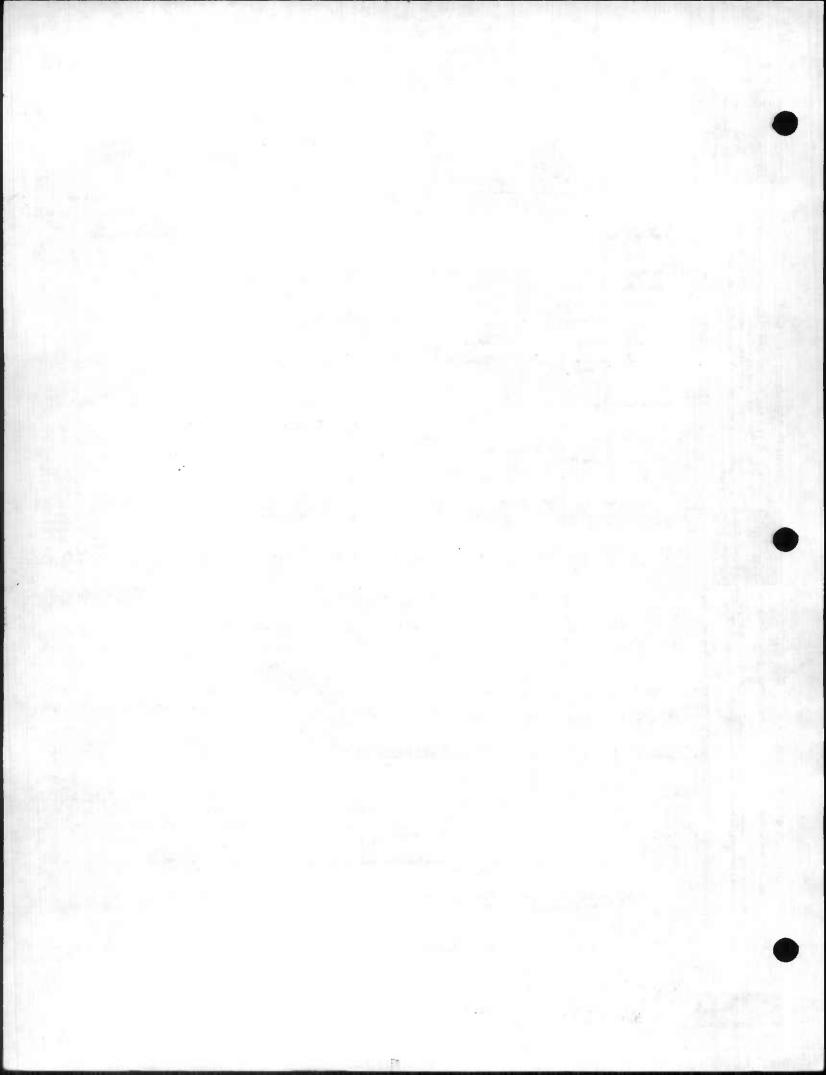
State of Maryland / Department of Health and Mental Hygiene 08599 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vest Physician Elizabeth V. Cascio 10:45 A.M. 2000 March /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2643 Dulany Street Baltimore N/A 8. Date of Birth (Month, Day, Year) If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 F 212-01-1589 96 June 12, 1903 Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland 280-7 N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 2643 Dulany Street 21223 United States 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Stelus 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: À 3 ☑ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Elementery/Secondary (0-12) College (1-4or 5+) Pages 1 and 2 should be filled with ment of Health and Mental Hygien aut; if fleen 27 is marked other thinty or other traumatic event, the Seamstress Manufacture 6th 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 89 Venturella Santa Serio Salvatore 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Marie Cascio/ Daughter 2643 Dulany Street Baltimore, Maryland 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 13/15/00 4 ☐ Donation 5 ☐ Other (Specify) New Cathedral Cemetery Baltimore, Maryland 21. Signature of Funerel Service Licensee 22. Neme end Address of Fecility Hubbard Funeral Home, Inc. Thomas uanita 4107 Wilkens Avenue Baltimore, Maryland 21229 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, about, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician CEREBROUASCULAR /Medical Immediate Cause (Final hours disease or condition resulting in death) Examiner Examiner ERE BROWASCULAR I NSUFFICIENCY ician and buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events ATHEROSchenosis Generalized 68760 Physician/Medical thal initieted events resulting in death) Last Due to (or es a consequence of) Box Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 2 1 No 1 Yes 2 No Division of Vitai Attending Physicien: 25. Wes case referred to medical examiner? Be 26. Placa of Deeth (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 1 BNatural 5 Pending investigation after death.
I Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 2 4 Homicide To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) ATTENDING MARCH 13, 2000 16200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 720-C MAIDEN Choicela, CATONSVIlle, DR. N. M. MACHIRAN 31. Date filed (Month, Day, Year)

Registrar

DHMH 16 Rev 6/95

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32 Registrar's Signeture



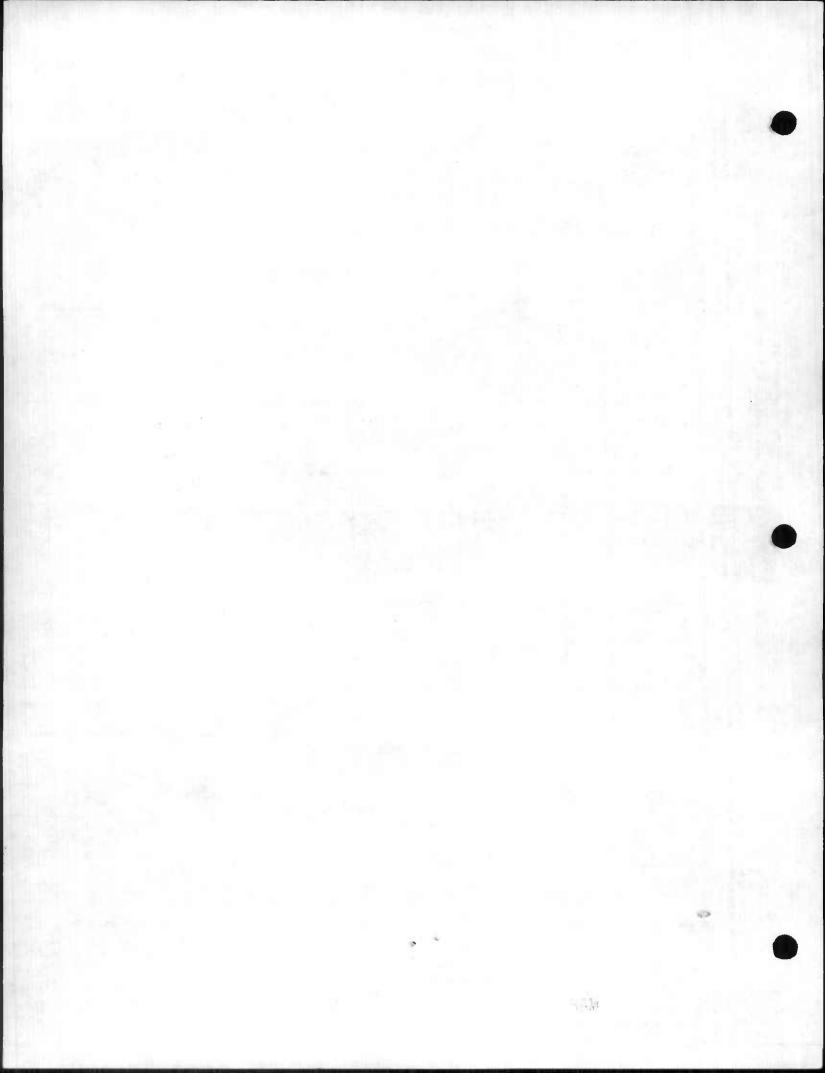
State of Maryland / Department of Health and Mental Hygiene 08600 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Year **Physician** BERNICE L. CLAY 08 MAR 2000 18:45 /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL COLUMBIA HOWARD If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) If Under 1 Year 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Months 10 M 20 F 77 067-18-8518 Yrs Director 1922 New York Usual Residence of Decedant 10a, Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Ellicott City Maryland Howard 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? 21043 7802 Mayfair Circle USA death v Funeral 14. Race - American Indien, Bleck, White, atc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 Never Merried 2 Merried 1 Yes 2 No 'natural', or Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 Widowed 4 Divorced White Yeer or Detes: Completed 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry filed within 72 I Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Insurance Company 17. Fether's Name (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked other any Injury or other traumatic availables. Be Alfred Barker Laon Lula Ethel Dawley 19a. informent's Neme/Reletionship (Type, Print) 19b. Malling Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21043 5395 Dunteachin Drive Ellicott City, Nano of Dete 20c. Location - City or Town, Stete David Scott Clay/Son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 3/9/00 Baltimore, MD 21. Signature of Funerel Servica Licensee 22. Neme end Address of Fecility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Edward A. regor che Edward A 21228 MD Gregorchik 23a. Part1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory arrest shock, or hear feilure. List only one cause on each line. Approximate Interval Batween Onset and Deeth **Physician** /Medical Immediate Cause (Final RESPIRATORY FAILURE diseese or condition resulting in death) Examiner Due to (or as a consequance of): Physician/Medical Examiner ATRIAL FIBRILLATION burial-transit and Sequentielly list conditions, if any, leeding to Immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Dua to (or as a consequanca of): certificate be swecu Box 68760. physician ATHEROSCLEROTIC HEART DISEASE, DIABETES the Due to (or es a consequence of) PERFORATED DIVERTICULITIS P.O. | Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably XX Unknown signed be de py Records, 24b. Were eutopsy findings evailable prior to completion of cause of deeth? should Completed 24a. Wes en eutopsy has 1 Yes XXNo 1 ☐ Yes 2 ☐ No certificate Division of Vital al or Attanding Physician: T s after death. I Director: After this certificat ed in by the funeral director, p Be 25. Wes case raferred to medical axaminer? 26. Place of Deeth (Check only one) Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medicai Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28a. Date of injury (Month, Day Year) 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledga, deeth occurred et the time, deta and place, and dua to the cause(s) and menner as stated.

2 Medical Examiner: On the bests of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) and mannar stated. 29e, Certifier 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0021768 d cause of death (from 23a) (Type, Print) 0 Merchant Deepak, M.D. 716 Maiden Choice Lane Catonsville MD 21228

Registrar **DHMH 16 Rev 6/95**

State

7 (35) Registrars Signeture



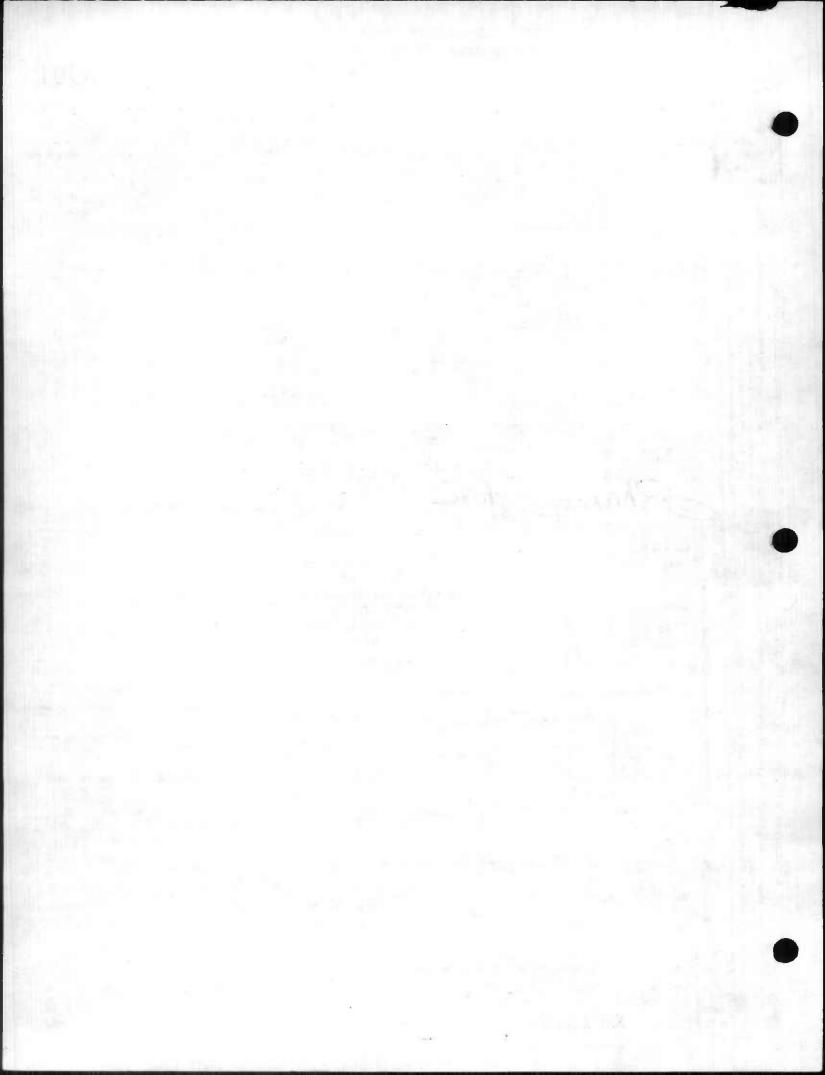
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Year Month Day **Physician** Dorothy Carson 0.3 2000 11 7:00am /Medical 4a Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Home Care Keepers Randallstown Baltimore Co. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) **Funeral** 1□M 200 F Director 215-14-9047 08 29 M.D 79 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County NON 2 No Directo Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 3502 Wabash Ave 21215 Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, Whita, etc. 1 Yes 2000 If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0020 b 1 Yas 2 No Specify: Specify: þ 3XXWidowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) Social Security Adm 12th grade Secretary 4yrs Maryland 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) it. Pages 1 and 2 should be fill artment of Health and Mental H ortant: If them 27 is marked oth Injury or other traumatic even Be Charles Moore Loretta Lewis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Charlene Hardison-Daughter 8 Pineknot Ct, Baltimore Md Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Nama of cematery, crematory or other place) 20c. Location - City or Town, Stata **K**OBurial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-16-00 Arbutus, Md Arbutus Mem. Park Depart mports any in) 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility March F/H West 4300 Wabash Ave, Baltimore Md enter the mode of dying, such as cardiac or respiratory arrest, 21215 needs, or complete from that caused the death. Do not enter Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition Examiner Dua to (or as a consequence of): Box 68760. bro Va Physician/Medical Dua to (or es e consequence of): 2 Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, à 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy Completed 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical 88 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No nul 1□ Yes 200-No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 器 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred care keigh er of De 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation Division Natural 1 Tyes 2 No **₹** Accident after death Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 6 To the Hospital within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical (Check only 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30 Nama and address of person who completed causa of death (Item 23a) (Type, Print) MD 21228 CATONSUILLE, ABATE 31 Date filed (Month, Day, Year) CNOSS 32. Registrar's Signatura State Registrar MAR 1 5 2000 Janer

ORIGINAL

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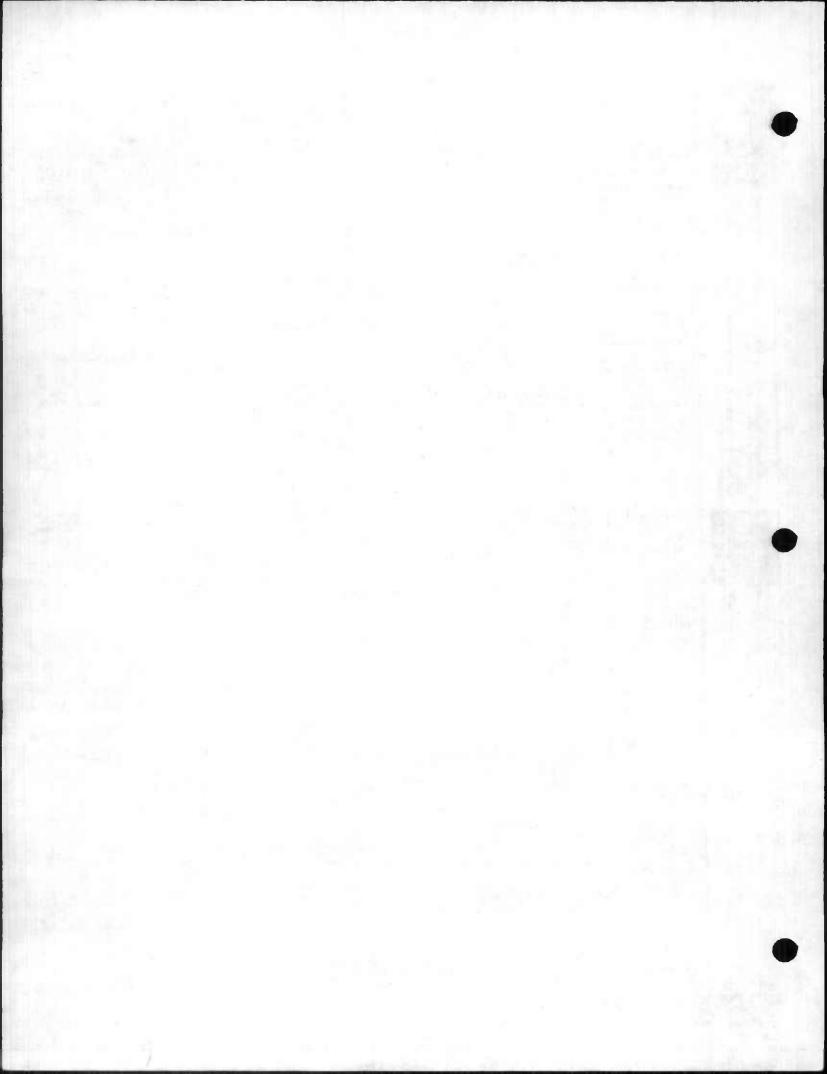
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month H **Physician** AL DLEMAN :19 Am 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE HOSPITAL CENTER If Under 24 Hrs. 8. Date of Birth If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 9 Birthplace (State or Foreign **Funeral** Months Deys 10 M 20 F Director 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits must be notified at 1 Yes 2 No Marylandi Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Menial Hygiene. Important: if filem 27 is marked other than "natural", or ferms 28s or is eny injury or other traumatic event, the Health 6 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No if Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Bleck, White, etc. 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. ,DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) der 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be eman 9 a 19a. Informant's Name/Reletionship (Type, Print) (Wife 19b. Mailing Address (Street and Number or Rucal Route Number, City or Town, State, Zip Code) Anna lemar 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition Date/ 20c. Location - City or Town, Stele 16/2000 1 Burial 2 Cremetion 3 Removel from State 4 Donation 5 DOther (Specify) 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Joseph Nor th Aue 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, shock or hourt failure. List only one cause on each line. Approximate tntervat Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Myo CARTIO Examiner Examiner Jension ettending physician and for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Phyaician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Division of Vitai Records. þ or Attending Physician: The lew requires 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed 1 Yes 2 No 1 Yes Be 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 R/Outpatient 3 DOA this 27. Manner of De 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Naturat 5 Pending investigation n 24 hours efter death.

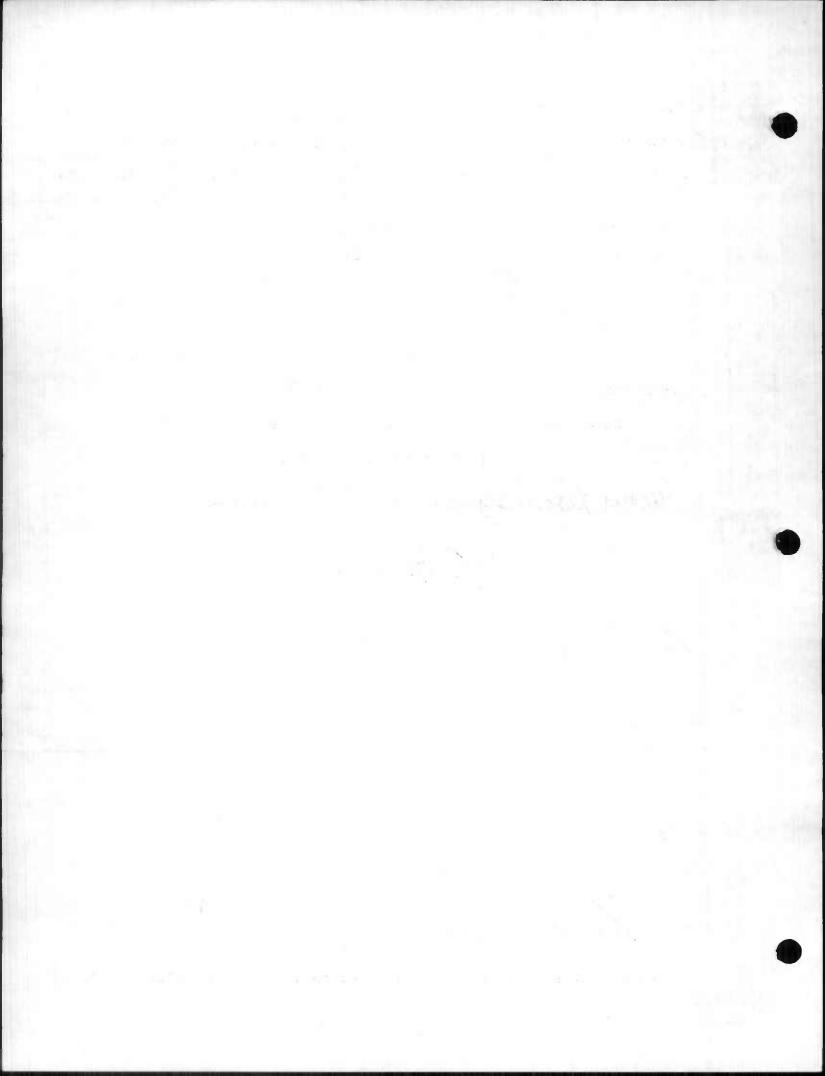
Ne Funerel Director: Afte pletely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, lerm, street, fectory, office building, etc. (Specify) 4 Homicide Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) To the I within 24 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hannuer St. Balto, Md. 21225 900 32. Registrar's Signature State 5 Registrar

ORIGINAL



Be Completed by Funeral Director	10e. Street and Number 10 Inchwell Coul 11. Maritel Status 1 Never Married 2 3 Widowed 4 Div 15. Dec. (Specify only)	6. Se 11 nt bunty Married orced edent's Edulighest greed	12. Was Dec Armed F 1 Yes, G Yeer or D	7. Age (In yrs 72 10c. C Balt	Yrs. ity, Town or Lo cimore Co	Months	or 1 Year Days		County	12, 2 Death	Dey 000 4c. County Baltin (r)	ore 9. Birthple Count Baltim	1:00am	r Foreign
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Be Completed by	10. Street and Number 10 Inchive 11. Could 11. Maritel Status 1 Never Married 2 Specify only 15. Dec (Specify only) Elementary/Secondary (0 12 12 17. Father's Name (First, M.)	Married orced edent's Edi	Armed F- 1 Yas tf Yes, Gi Yeer or I	edent Ever in Uorces?	J,S. 13. \	10f. Zi	n Code							y Limits
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e a	Elementary/Secondary (0 12 17. Father's Name (First, M	ighest gred	unation					uban, Mexican, Puarto Rican, etc.)			Black, White, etc. Specify: White			
e a	Elementary/Secondary (0 12 17. Father's Name (First, M		ucation 16a. Decedent's Usuat Occide completed) (Give kind of work don						16b.	Kind of Bu	usiness/Indu			
e a		Elementary/Secondary (0-12)			College (1-4or 5+)				retired)					
m		ddle l act)	N/A Housewif			te		10 Mather's	Inmo /First 84	Housekeeping -			n Home	
2				Cathe					e Tajtis					
	19a. Informent's Name/Relationship (Type, Pnint) Bonita Mooney (Daughter) 19b. Mailing Address (Street and Number or Rural Ro 10 Lochwell Court Baltimore, M											State, Zip (Code)	
1 +	20a. Method of Disposition	erel ire	20b. Placa of Disposition (Name of									City or Tov	n, Stata	
	1 ☑ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth							000	Bali	timme	,Maryla	and		
	21. Signeture of Funerel Se				22	2. Nama a	nd Addre	ess of Fecility						
	23a. Part1. Enter the disear shock, or heart failure	Les	lications that	grade	1 74	OI Be	lair	ral Home Road Balt	imore, M	arylan	1 2123		Approximate	
pa	sequentially list conditions, if any, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in deeth) Last	{	Due to (or as a consequenca of): Due to (or as a consequenca of): C											
Clan	Port II Other algorificant co	aditions on	ontributing to death but not resulting in the underlying cause given in Pert f.						001	Didashas				
by Physician/M	Pert II. Other significant co	iditions co	The state of the second of the state of the						23b. Did tobacco use contribute to the cause of de					
Completed b									24a. Was en eutopsy performed? 24b. Were a avaitable complei of delet			table prior to plation of ca		
Be Be									1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 ☐			Yas 2□ N	Vo	
	25. Wes case referred to me exeminer?		11 11 11 11 11 11 11 11 11 11 11 11 11					Death (Check o	ath (Check only one)					
tion: To	1 Yes 2 X No 27. Manner of Death 1 XNatural 5 Pending 2 Accident investigatio		Hospital: 1 Inpatiant 2 ER/Outpetient 3 ER/Out				X			☐ Residence 6 ☐ Other (Specify)				
Medical Certification:	3 ☐ Sulcide 6 ☐ C	ide 6 Could not be							28f. Locat City o	28f. Location (Street end Number or Rural Route Number, City or Town, State)				er,
	29e. Certifier Certifier (Check only one)	tifying Phy	ner: On the b	best of my kno asis of examina ner stated.	ny knowledge, death occurred et the time, date end pleca, e amination and/or investigation, in my opinion, deeth occurre					a, end due to the causa(s) end menner es stated. urred at the time, date end pleca, and due to the ceuse(s)				
	29b. Signature end all of	West /	29c. License number D1550 +					L	29d. Date signed (Month, Day, Yea					
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 2									21093	3			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

08604 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day 9 30 HAS Year **Physician** Flossic B Carter MARCH 2000 05 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2#F 237 40 1267 77 Director S.C Usual Residence of Decedent 10a. Stete 10b. County 10d. Inside City Limits 10c. City. Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at HOYes 2□No Director BALTIMORE MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4501 MANORDENE 21229 RD. USA death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Black, White, etc. AFRO Race - American Indian. 11 Marital Status 72 hours after 1 Yes 2# No If Yes, Give Year or Dates: 1 Never Married 2 Merried Baltlmore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: AMERICAN P 3# Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Important: If Nem 27 is marked other the
any Injury or other traumatin HOME HOMEMAKER 12 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) Be CALHOUN ANDREWS MAUDE B. ANDREWS 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) JOHNNIE BOONE McCREA 919 FLORAL AVE. SUMTER, S.C. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State MT. ZION 4 ☐ Donation 5 ☐ Other (Specify) 3/10/2000 LANSDOWNE, MD. 22. Name and Address of Facility HERS FUNERALHOME 21. Signeture of Funeral Service Licenses 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. 1300 EUTAW PL. BALTO. MD. 21217 Approximate Interval Between Onset and Death **Physician** ASPIRATION PHEUMONIA

Due to (or as a consequence of): Immediate Cause (Finet disease or condition resulting in death) /Medical Examiner MASSIVE CEREBROVASCULAR ACCIDENT Examiner physician and the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last HEART CONGESTIVE Physician/Medical 980 P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No VItal 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 25 No 1万 Inpatient 2 ER/Outpatient 3 DOA o 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation Division 1 Yes 2 No hours after death. 2 ☐ Accident Director 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signeture and title of certified 29c. License number 29d. Date signed (Month, Dey, Year) MARCH-OS-2000 30. Name and address of person Tho completed cause of death (Item 23a) (Type, Print) 57 BALTIMORE M.O 21229 AGNES OBENG SIMEONI 31. Dete filed (Month, Day, Year) MAR 1 5 2000 32. Registrar's Signature State oaks Registrar

DHMH 16 Rev 6/95

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Flossie

State of Maryland / Department of Health and Mental Hygiene 08605 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 8:20 PM Edward J. Derby 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner JERBY LOWARD CENTER
birthday) If Under 1 Year
Months Days ROSEDALE

If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
May 27, 1927 SQUARE HOSPITAL FRANKLIN BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10XM 20 F Director 214-22-1530 Pennsylvania **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show 1 ☐ Yes 2 No Director Maryland Baltimore White Marsh 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5710 Allender Road 21162 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. Armed Forces?
1 1 Yes 2 No NAVY
If Yes, Give
Year or Dates: 1945-46 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: à 3 ☐ Widowed 4 ☐ Divorced "natural", White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. Mechanic n/a Trucking Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Peges 1 and 2 should be file Department of Health and Mantel Hy Important: if Item 27 is marked oth any Injury or other treumatic event ands. 8 James E. Derby Mildred Van Fussin 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris G. Derby (Wife) 5710 Allender Road White Marsh, MD. 21162 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stele 1 Burial 2 Cremetion 3 Removel from State Garrison Forest Cem. 4 ☐ Donation 5 ☐ Other (Specify) 3/13/2000 Baltimore.MD. 21. Signature of Funeral Service Lio 22. Name end Address of Facility E.F.LaSSAHN Funeral Home 11750 Belair Road Kingsville, MD. 21087 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete tntervel Between Onset and Death **Physician** /Medical Immediate Cause (Final PNEUMONIA ASPIRATION DAY disease or condition resulting in death) Examiner ONGESTIVE FAILURE HEART WEEKS physicien and s the buriel-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) 68760 ORONARY ARTERY ISEASE TEARS Physician/Medical Due to (or as e consequence of) Box P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 2 3 Probably 4 Unknown 1 Yes 2 No ped ed b Records, à 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes en eutopsy 1 Yes 2 No 1 Yes 2 No Division of Vital Attending Physician: 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Aln 24 hours effer death.

Funerel Director: Afternet In by the for After 5 Pending investigation 1 20 Natural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. edicai 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) on MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ORIGINAL

9000

FRANKLIN SQUARE DRIVE BALTIMORE MARYLAND 31937

ALEXANDER H.D.

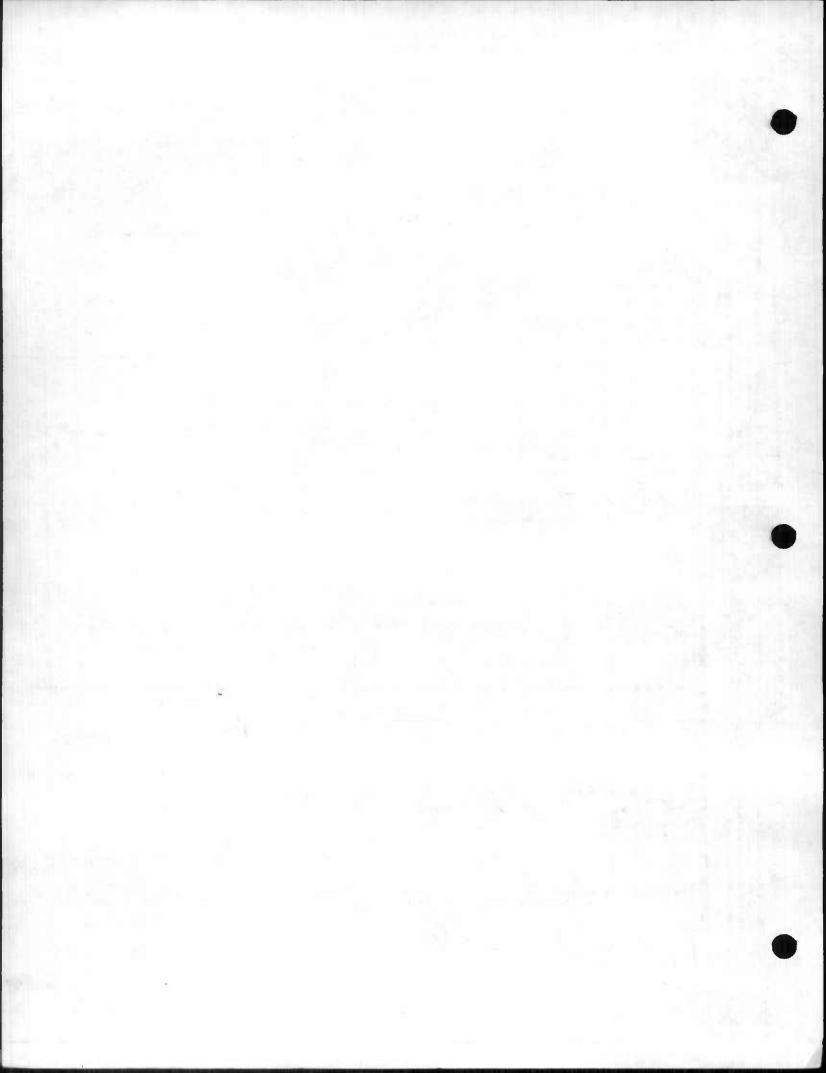
DANIEL

State

Registrar

31. Date filed (Month, Day, Year)

MAR 15



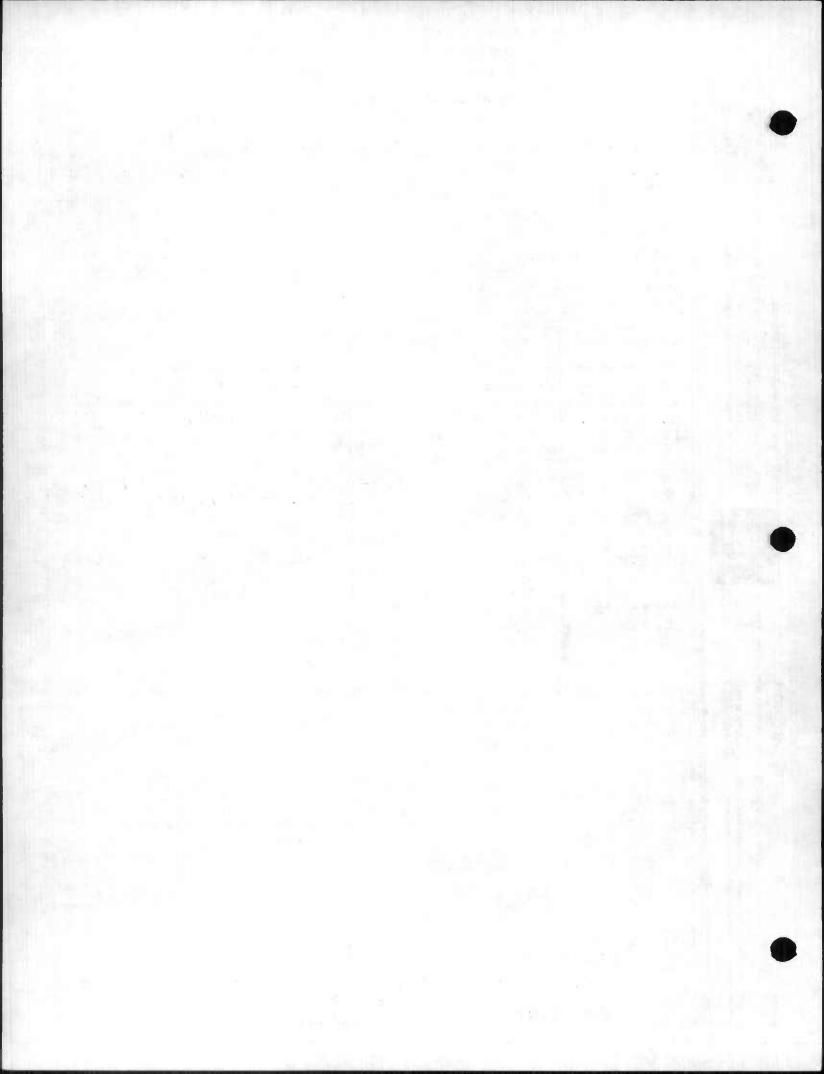
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

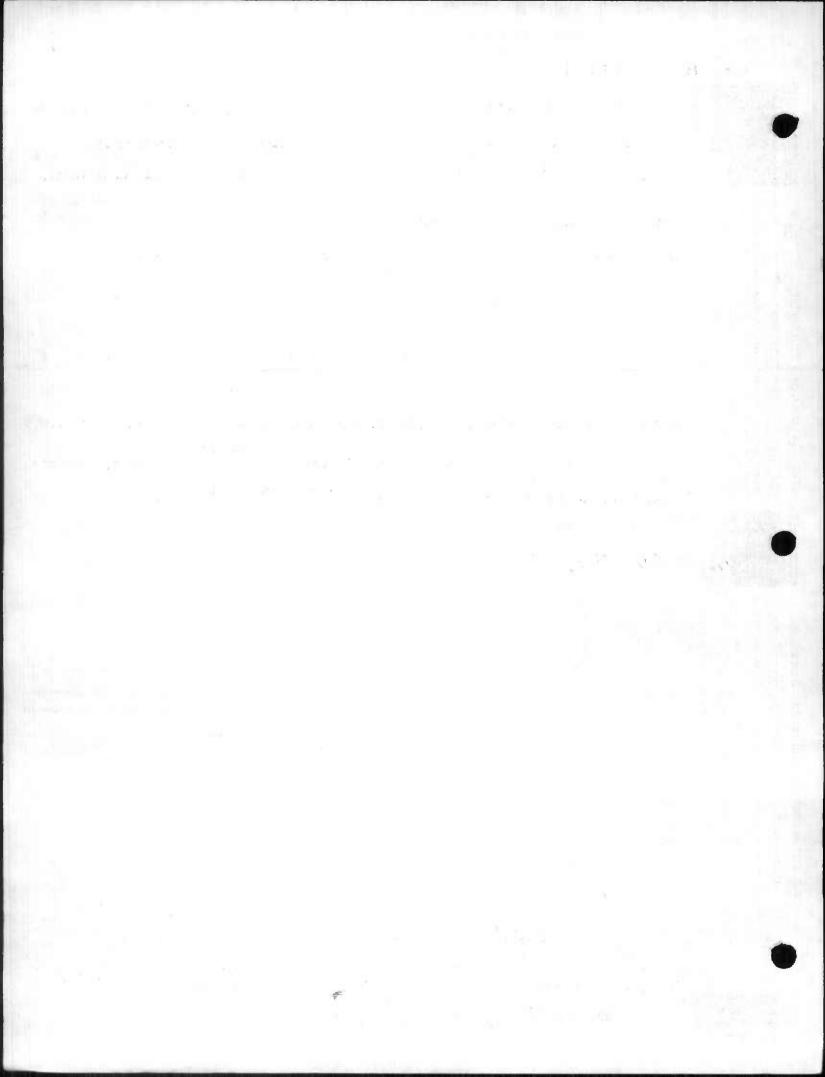
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			Ce	ertificate	of Death		Reg. No.	U	0000				
Chusisian	1. Decedent's Name (First, Middle, Li		3	- 7		2. Date of I	Death Day	Year	3. Time of Death				
Physician /Medical		Wava G	lendora	Dodge		March	13,20	000	11:30AN				
Examiner	4a Facility Name (If not institution, give	ve street and number)			4b. City, Tow	n, or Location of De	ath 4c. Count	y of Death					
	tranklin Squar		Center	7 22 22 2 2 2	Kose			timor					
uneral		1□M 2□XF	n yrs. last birthday	Months	Year If Under 2- Days Hours	Min. (Month,	Date of Birth (Month, Day, Year) 9. Birthplace (State or Fine Country)						
or 28a-f show be notified at Director	Usual Residence of Decedent	214-44-4072 71 71 July 26,1928 West Virg											
	10a. State 10b. County	10	c. City, Town or L	ocation				11	Od. Inside City Limits				
	Maryland Baltimore Dundalk												
	10s. Street and Number 10f. Zip Code 10g. Citizen of What												
	8104 Bullneck 1	Road			21222)	United	Stat	es				
Funeral	11. Marital Status	12. Was Decedent Eve	r in U,S. 13.	Wes Decede		in? (Specify Yes or I Puerto Rican, etc.)		ce - Americ	an Indian,				
	1 Never Merried 2 Married	Armed Forces? 1 Yes 2 No				Puerto Hican, etc.)			ack, White, etc.				
by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:		1L1 105 21	No Specify:		Speci	D.	White				
Completed	15. Decedent's E (Specify only highest gro	ducation	de completed) (Give		Occupation done during most of	nf working	16b. Kind of E	Business/Inc	dustry				
Jq.	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)								
	10 Years		Н	ousewi				1 Home	9				
8	17. Father's Name (First, Middle, Last				lle, Maiden Suma	me)							
2	Charles Frankl:					ie Blair							
To Be C	19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, 2 Nr. Ronald F. Dodge (Husband) 8104 Bullneck Road Dundalk, Maryland												
	20a. Method of Disposition		20b. Place of Disp			Dete	20c. Location		21222				
	1 Burial 2 □ Cremation 3 □	Removel from State	cemetery, cri	emetory or oth	er place)								
	4 Denailer) 5 Other (Specify) Terra Alta Cemetery 3/18/00 Terra Alta, WV												
	Duda-Ruck Funeral Home of Dundalk, Inc.												
	7922 Wise Ave. Dundalk, Maryland 21222 23 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate												
	234 Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Or heart feilure. List only one cause on each respiratory. Approximate Interval Between Onset and Death												
1	Immediate Cause (Finat												
и	Immediate Cause (Finat disease or condition resulting in death) a												
è		· Preumo		equerice or).				8 5					
Examiner	Sequentially list conditions	b. Theolyto	to (or es a conse	equence of):				1					
Ä													
edical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of):												
leted by Physician/Medical Examin	. Lymphoma Non Hodgkins												
5		0.1		1.10.11	311			1					
Physician/	Part II. Other significant conditions of	contributing to death but no	23b. D	23b. Did tobacco use contributa to the causa of de									
4			10	1 ☐ Yes 2 No 3 ☐ Probably 4									
d b	24a. Wes an autopsy performed?								are autopsy findings				
e e									ere autopsy findings allable prior to impletion of cause				
E									deeth?				
the Funeral Director: After this cer spietally filled in by the funeral direct edical Certification: To B	25. Was case referred to medical				00.50			11	Yes 2 No				
	examiner?	Hospital:	2 EB/Outpotic	2□ DOA	Other	of Deeth (Check onl		has /Canaih					
	27. Manner of Death	28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred											
	1 Natural 5 Pending 2 Accident investigatio		ar) Injury	М	0								
	3 ☐ Suicide 6 ☐ Could not be determined	288. Piece of Injury -	ece of trijury - At home, farm, street, fectory, office 28f. Location (5						(Street and Number or Rural Route Number, wn, State)				
	4 Litomore	building, etc. (5	респу)			Oily of a	Own, Oleter						
	(Check only 2 Medical Exar	ysicien: To the best of miner: On the basis of exa											
	one) and manner steled. 29b. Signature and title of certifier 29d. December 29d. Dece								te signed (Month, Day, Year)				
	1100			1	111575	20	March 13,2000						
	30. Name and address of person who	completed cause of death	(Item 22s) (Time	Print\	ノナンノロ) /	i i-ti ch	ه را د ا	,000				
	De Wilbur Roes	9000 5	an Klin	Squar	Drive	e Battim	ore mil	2123	37				
State	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	-			٠٠- ١٠ م	\$ 101					
istrar	MAR 15	2000 Des	was ,	Ø. 1	on Val								



State of Maryland / Department of Health and Mental Hygiene Amended Item#3 perPHYG781 3/15/2000 EW Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Year **EVERARD** MONROE 25, Feb. 2000 12;20 PM /Medicai 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Circle Manor Nursing Home Wheaton Montgomery If Under 1 Year if Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Oct. 25, 1 5. Social Security Number 7. Age (In yrs. lest birthday) Birthpiace (State or Foreign Country) **Funeral** Days 1 X M 2 □ F Director 78 Yrs 1921 218-66-7552 West Indies Usual Residence of Decedent the Meryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28a-f show traumstic avent, the Madical Examiner must be notified at 1 ☐ Yes 2 No Director Md. Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 10231 Carroll Place 20895 U.S.A. death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours efter Department of Heelith and Mental Hygiene. Introductant: If Nem 27 is merked other than "natural; or ite any injury or other traumatic avant, the Medical Examine 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☒ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) D.C. Government Maintenance Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Monroe Douglas 2 Ruby Edwards 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Charmaine Julien (daughter) 9310 S. Dairy Ashford Rd. #3505, Houston, TX 77099 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete Feb. 29 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 2000 Alexandria, Virginia 22. Name end Address of Fecility Price Funeral Home, Inc. 9609 Center St. Manassas, Virginia 20110 The disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, user failure. List triy one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in deeth) Meumonia Examine Due to (or as a consequence of): Examiner the deeth certificate be executed buriel-trensit Sequentially ilst conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last and Due to (or as a consequence of): physician s the buriel Box 68760, Physician/Medical Due to (or as a consequence of): attending esn jo Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? the deteched signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? peen page 2 hes 2/25No certificate 1 Yes 2 No Division of Vital 25. Wes cese referred to medical Be 26. Place of Death (Check only one) examiner? examiner r 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 9 this 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred i or Attending P efter death. | Director: After t Certification: 1 Naturel 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Piace of injury - At home, farm, street, factory, office building, etc. (Specify) lilled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 20d. Date pigned (Month, Dey, Year) 30. Name and address of person who completed ceuse of death (Item 23al (Type, Print) VE KENSINGTON 3720 32. Registar's Signature 31. Date filed (Month, Dey, Year) State Denewa Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Thomas C. Esender 11:05 am March 2000 /Medical 4a Facility Nema (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Catonsville Charlestown care Center Hours Min. 8. Dete of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 101M 20 F Months Yrs. 214-03-7742 Director 84 8, 1915 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits r than "natural", or flome 23a or 28a-f ahow the Medical Exampler must be notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Catonsville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 707 Maiden Choice Lane, Apt. 8204 21228 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 72 hours after 1 X Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Merried 1 ☐ Yas 2 ☐ No Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Hygiene. Elamentery/Secondary (0-12) College (1-4or 5+) permit. Peges 1 and 2 should be filed will Department of Heelth and Mental hygient important: If item 27 is marked other that any fulury or other traumatic event, that pace. 12 0 Supervisor Public Utility Co. 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Edward H. Esender Rachel Griffin 19e. informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) 21228 DOrothy C. Esender / Wife 707 Maiden Choice Lane, Apt. 8204, Catonsville, Md. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Deta 1 ☐ Burial 2 X Cremelion 3 ☐ Removel from State Metro Crematory 3/11/00 Baltimore, Maryland 4 ☐ Donalion 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heer failure. List only one ceuse on each line. Approximata Interval Between Onset end Death **Physician** /Medical Immediete Cause (Finel End Stage Congestive Meant failure Years disease or condition resulting in deeth) Examiner physician and s the buriat-transit Sequentielly list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaase or Injury that initieted events resulting in daeth) Last Due to (or as e consequence of): Physician/Medicai Due to (or es e consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown É 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2) No 1 ☐ Yes 2 No Attending Physician: 25. Wes case raferred to medical axaminar? Be 26. Place of Deeth (Check only one) Other: Nursing Homa 5 Residence 6 Other (Specify) edical Certification: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Panding Investigation Natural 1 Yes 2 No 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At homa, farm, street, fectory, office building, etc. (Specify) after A 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 1 Certifying Physician: To the best of my knowledga, death occurred et the time, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 51051 March 10, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

21215-0020

Baltimore, Maryland

Thomas

Name

Vital

Division of

DHMH 16 Rev 6/95

Salazar

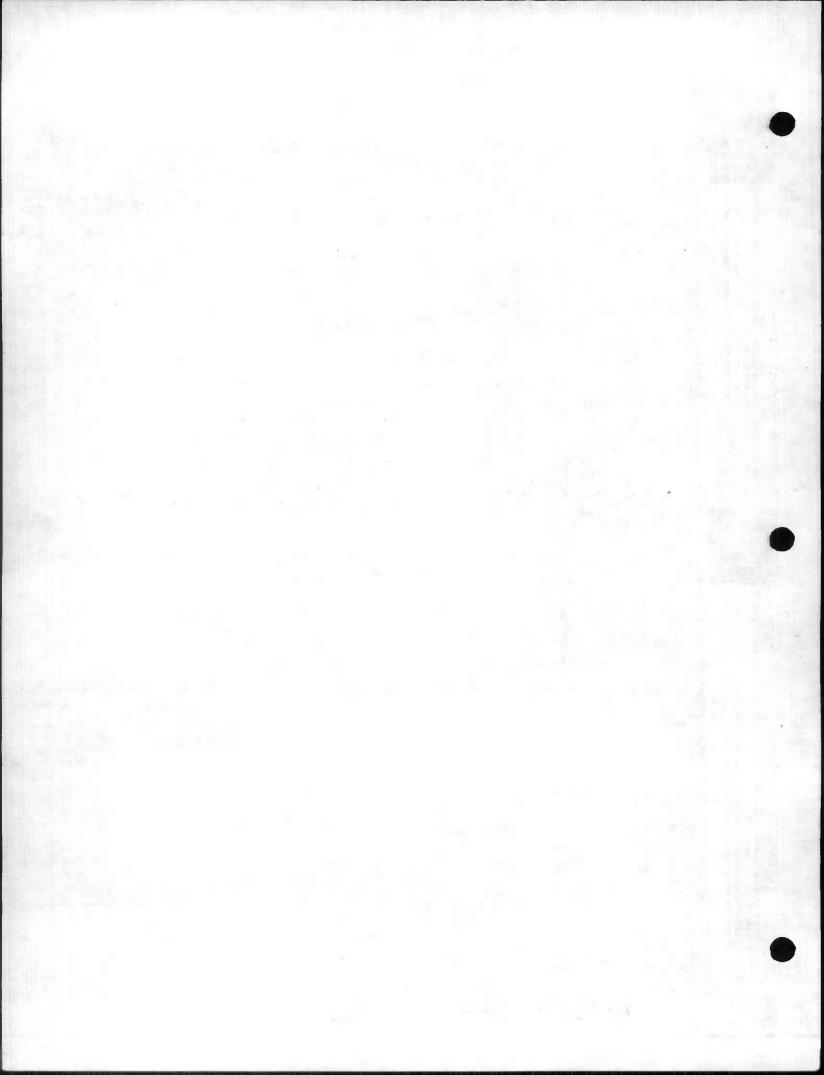
31. Date filed (Month Dev. Year) 2000

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Registrer's Signeture

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Lane, Contonsville, MD, 21228



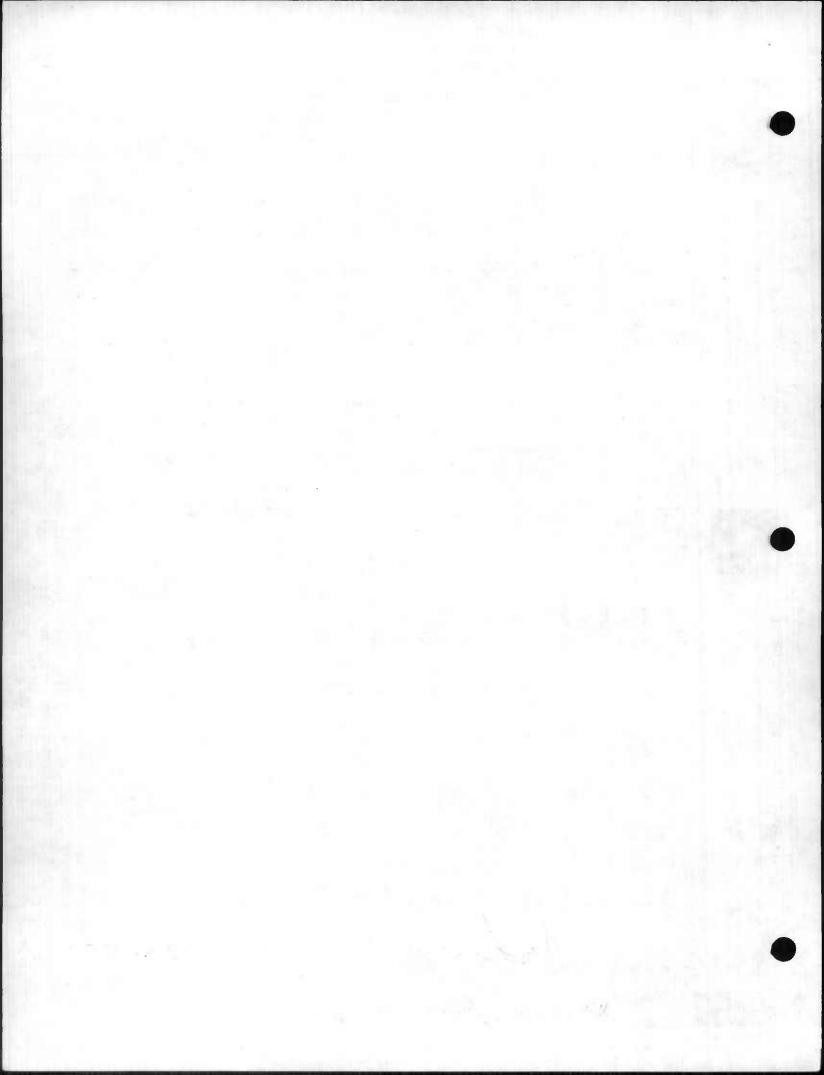
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pletery III		er: On the basis of examine and mannar stated.	etion and/or Inv	estigation, in my	opinion, death occ	urred at the time	, date and place	and due to th	e cause(s)
To the Funesi completely Illie Medical C	29b. Signature and title of certifier	/	10		nse number		29d. Date sign		
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9	30. Name and address of person who cold DRDAN TRAN 90	mpleted cause of death (Ite	m 23a) (Type, F	Print)	2 Baltin	ace a	DAL	0217	
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State of Maryland / Department of Health and Mental Hygiene

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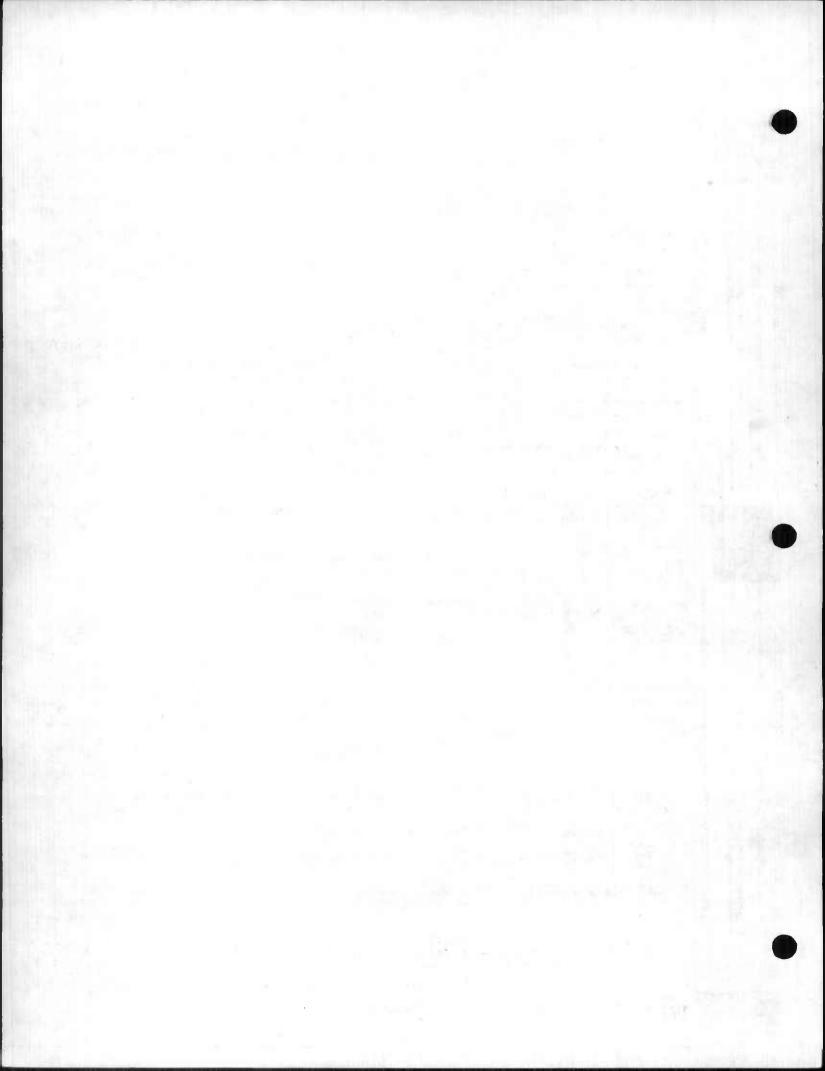
Registrar



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State of Maryland / Department of Health and Mental Hygiene O O

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17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidle Sumama) Mary Castle Blair	
Vickie L. Fisher (spouse) 20a. Method of Disposition 1	
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29a. Certifier (Check only ane) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and mennary and the time, date and place, and due to the cause(s) and the time, date and place, and the time, date and time and time and time and time and time.	
29b. Signature and title of certifier 29d. Date signed (Mor	is stated. ia to the ceuse(s)
d Herlt P. Henden 17 MD DO051924 March 13	ua to the ceuse(s) nth, Day, Year)
Jett P. Henden DWD D0051924 March 13. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Herbert P. Henderson Jr. MD 295 Stoner Are Suite 307 West State 31. Data filed (Month, Day, Year) 32. Registrar's Signatura	ua to the ceuse(s) nth, Day, Year)



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 53 0.07 RINK 2000 117 4b. City, Town, or Location of Death 4c. County of Deeth timere If Under 24 Hrs. 7. Age (In yrs. last birthdey) If Under 1 Year 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) Days Months Hours 1 M 2XF 18-0791 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 18 Yes 2 No Baltimore none YARY LAND 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21217 USA 717 Druid Park Lake Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 14. Race - American Indian, Black, White, etc. Yes 2 No 1 Never Merried 2 Married 1 Yes 2 No Specify: Afro American 3 ₩idowed 4 Divorced Year or Detes: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWN Home tome maker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) HARRI TRue heart YAGER RINK 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edmondson Ave Baltimore Md 21223 2603 (Ulgeni E 20b. Plece of Disposition (Name of cemetery, crematory or other plece) Date 20c. Location - City or Town, Stete 20e. Method of Disposition Buriel 2 Cremetion 3 Removel from State 4 □ Donetion 5 □ Other (Specify) len BURNIE MARY land 22. Name and Address of Facility NAMCY M. WALLACE Funchas Serving 3405 W. FRANKIN St BAKIMOR, Md 21229 21. Signetury of Funeral Service Licensee Collace for the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest hear failure. List only one cause on each line. Approximete Intervel Between Onset end Death Immediate Ceuse (Final disease or condition resulting in deeth) Due to (or as a consequence of): Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in deeth) Last Due to (or es e consequence of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? 26. Placa of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

Examiner The law requires that the death certificate be asscuted Box 68760 P.0. Records, Division of Vital Attending Physician:

Physician

/Medical

Examiner

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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi Registrar

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State

31. Dete filed (Month, Dey, Year) 5 2000 MAR 1

29b. Signeture and title of certifier

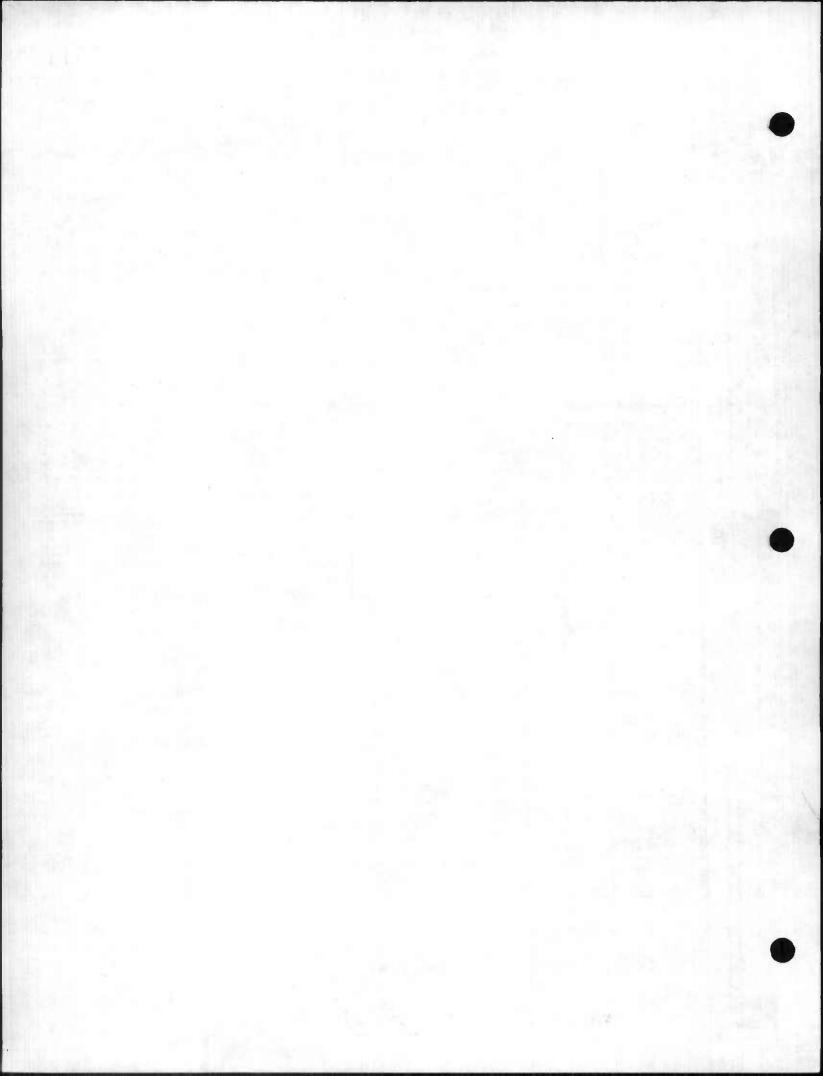
32. Registrar a Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print



29c. License number

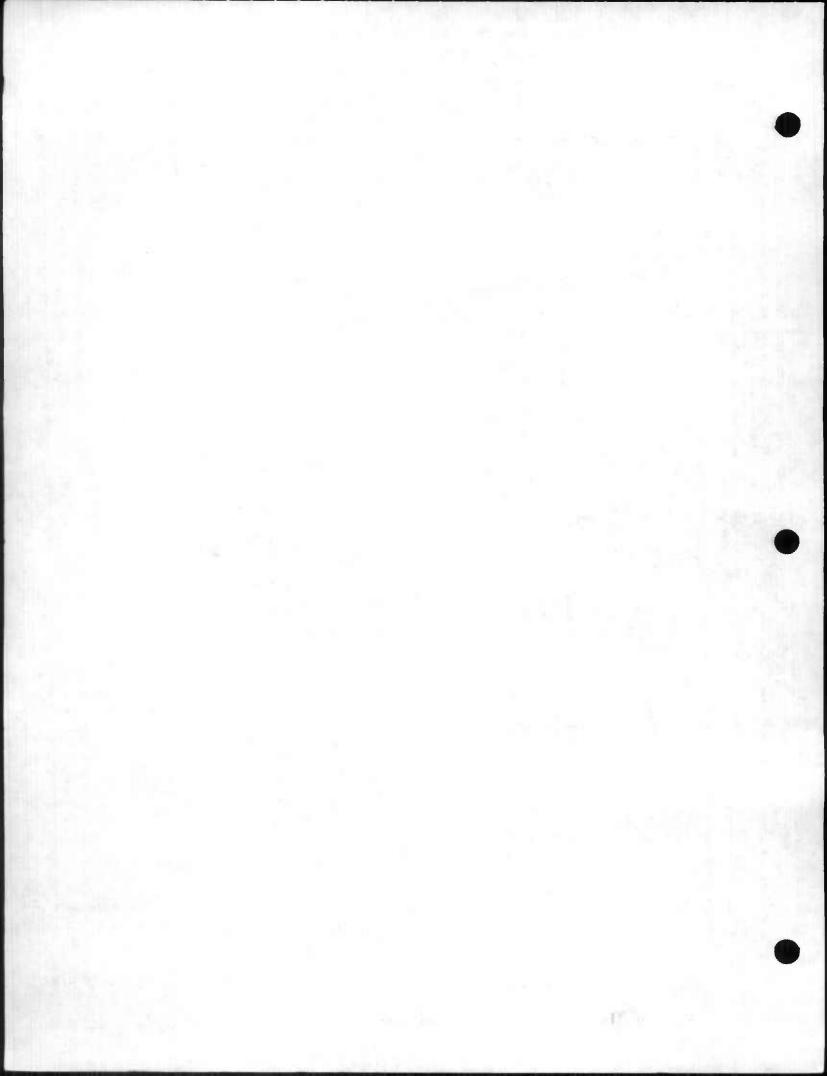
29d. Date signed (Month, Day, Year)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 086 12

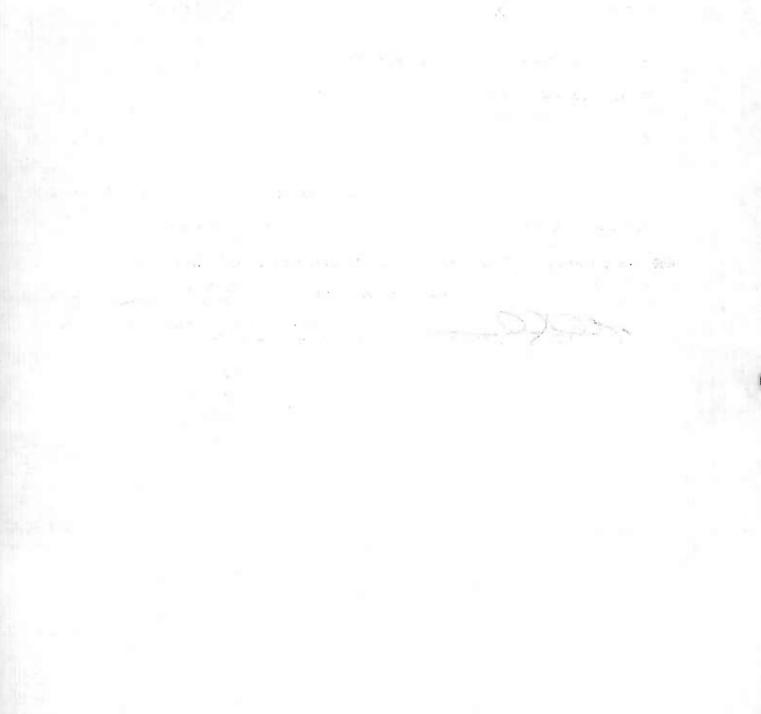
					Ce	rtificat	e of	Death			Reg. No.		00012	
hysician	1. Decedent's Name EDYTHE	(First, Middle, La	st) JOF	ਸ਼ਬ			FADE	ER		2. Date of De Month MARCH	ath	OOYear	3. Time of Death 7:50AM	
Medical xaminer	4a Facility Name (#		e street end nun	nber)	INT HOM	1E		Ib. City, To		ocation of Deeth		ty of Death		
neral ector	5. Social Security No. 220–46–71	umber 6. S		7. Age (In yrs. 92		7 2071	1 Year	If Under Hours		8. Date of Bird 9 Month Da			place (State or Fore ntry)	
nd at	Usuat Residence of 10a. Stete	Decedent 10b. County BALTIMO	DRE.		ity, Town or L								10d. Inside City Lim	
Director	10e. Street and Num	nber	7115		ICEO VIE	10f. Ziş					10g. Citizen of		**	
examiner must be notified at by Funeral Director	7 SUDBROC 11. Marital Status 1 Never Marria 3/2/Widowed	ed 2 Married	12. Was Dece Armed For 1 Yes If Yes, Giv Year or De	ces? 2	J,S. 13.			lispanic Ori an, Mexicer Specify:	gin? (Sp , Puerto	pecify Yes or No Rican, etc.)	- 14. Ra Bi	JSA ace - Ameri ack, White, if/WHIT	etc.	
	(Speci	15. Decedent's Enify only highest gra	de completed)		(Give	a kind of wo	ual Occupation work done during most of working use retired)				16b. Kind ot i	ndustry		
Completed	Etementery/Secon		College (1	-4or 5+)	NURSE		1		de Maria	o (Fires Adiabate	MEDICI:			
To Be	17. Father's Name (rirst, Middie, Last,		CAN	TOR			18. Mothe		BTAINAE	st, Middle, Maiden Sumeme) AINABLE			
	19a. Informant's Na		Type, Print)			o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 LABYRINTH ROAD BALTIMORE, MD. 21208							p Code)	
	20a. Method of Disposition 1 Magnetical 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) SHAREI TFILOH CONG 20c. Location - City of MARCH 13 WOODLAWN, M													
8500	21. Signature of Full			SHA	2	22. Name e	nd Addre	ss of Facili	SOL	LEVINSOROAD PIE	ON & BR	os. I	NC.	
s the burial-transit ucal ucal edical Examiner	23a. Part1. Enter the shock, or hear the shock or condition resulting in deeth)	Final	a.									1	Approximate Interval Between Onset and Death	
n/Medicai Examiner	Cause (Disease or injury that initiated events that initiated events resulting in death) Last Due to (or es e consequence of):													
Physician/	Part II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of			to the cause of dea	
d by Physician/Me	Ac	2401	1 ERS							10	Yes 2□ No	3 □ Pro	obably 4 Minkn	
pleter				4						24e. Wes	an autopsy ormed?	a	Vere autopsy finding vaileble prior to ompletion of cause t deeth?	
ro Be Com	25. Was case refer	ed to-medical					_	26 Place	od Dee	1 □		1	☐ Yes 2 No	
0	examiner? 1 Yes 2 2 27. Manner of Death	No		npatient 2 [of Injury h, Dey Year)	ER/Outpatie		OA Oth	ner: 42 Nu		ome 5 ☐ Resi 28d. Describe	dence 6 🗆 O		ify)	
Certification: T	2 Accident 3 Suicide 4 Homicide	investigetio 6 Could not be determined		of Injury - At h	nome, farm, s	treet, factor		Yes 2	No	28f. Location (City or To	Street and Nur wn, Stete)	mber or Ru	ral Route Number,	
Medical Certificat		1 Certifying Pt 2 Medical Exam		sis of examina										
×	29b. Signature and	title of certifier	La	lha	ni	29	c. Licens	e number	95		29d. Date sign	and (Month	, Day, Year)	
	30. Name and addre	ess of person who	completed caus	of death (Ite	m 23e) (Type	Print)	H	EIGH	175	AVE	BA	cro.	M) 2/20	
State	31. Dete filed (Mont		32. R	egistrer's Sign	ature	1								



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 086 |

Physiciar					00		6 01	Death			Reg. No.				
envsinia.		1. Decedent's Neme (First, Middle	, Last)							2. Dete of De Month	eth Dey	Year	3. Time of Dear		
/Medica	_	Mae Elizab	eth Gav	er						0.3		2000	11:00		
Examine		4a. Facility Neme (If not institution	, give street and nu	mber)				4b. City, To	wn, or Lo	cation of Deet	h 4c. Cour	ty of Deeth			
		Maryland Mas	onic Ho	mes				Cock	eysu	ille	Ва	ltimo	re		
uneral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthdey)	if Under Months	1 Year Days		24 Hrs. Min.	8. Dete of Bir	th Vees	9. Birth	piaca (State or For		
irector		215-22-7511	1 □ M 2 F	91	Yrs.	Monus	Days	Hours	IVIII.	127	7908	Cou	MD		
	- 1-	Usuel Residence of Decedent		10.00											
a de		10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside City Lir		
THE ST	2	MD Balt	imore		Cockey	svill	e						1 Yes 2€		
or 28a-f show be notified at	5	10e. Street and Number				10f. Zip	Code				10g. Citizen o	f What Cou	ntry?		
230	2	300 Internation	onal Cir				21	1030			J	JSA			
al', or items 23s or 28a-f si Examiner mast be notified by Emerci Director	2	11. Marital Status	12. Was Dec	edent Ever in U,: prces?	S. 13.	Wes Deced	dent of h	Hispanic Or an, Mexicar	gin? (Spe	cify Yes or No Rican, etc.))- 14. R	ece - Ameri lack, White,			
0 =	L ÁG	1 Never Married 2 Marri	ed 1 ☐ Yes If Yes, Gi					Specify:				fy: Whi			
F 4		3 Widowed 4 □ Divorced	Year or E	Pates:											
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If it	3	17. Father'a Name (First, Middle, I	N/	A		Sales	CTE		ar'a Name	(First Middle	, Maiden Sum	-	ent Stor		
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Tis marked other than treumatic event, the M	- 1			. 1							er, City or Tow				
item 27 i other tr		Robert W. Gaver,	Jr./Gra		laca of Dispo			ew Ave	1 .5	Date	re, MD				
= -	1	1 Buriei 2 □ Cremation		CHAIL CE	emetery, cret	natory or o	ther pla	ce)	M	arch 14	200. Location	1 - Only Or 1	Own, State		
important: if any injury or once.	4 Donation 5 Other (Specify) WOOdlawn Cemetery 2000 Woo											lawn,	MD		
eny ir	1	21. Signature of Funeral Home of Dulaney Valley, Inc.													
200		21. Signature of Funeral 22. Name end Address of Facility													
		23a. Part1. Enter the diseese, or shock, or heart feilure. List of	complications thet only one cause on e	caused the death	. Do not ent	er the mod	e of dyir	ng, such es	cardiec o	or respiratory a	rrest,		Approximate Interval Between		
sician													Onset end Death		
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physician end s the bunal-transit		Sequentially list conditions,	D	Due to (or	as a consec	quence of):						1			
urial-	1	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.													
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		resulting In death) Last	d												
or us		resulting in death) Last Part fi. Other significant condition	d	eath but not resu	ilting in the u	nderlying c	ause giv	ven in Part	1.	23b. Did	tobacco use o	contribute t	o the cause of de		
or us		resulting in death) Last Part fi. Other significant condition									tobacco use o				
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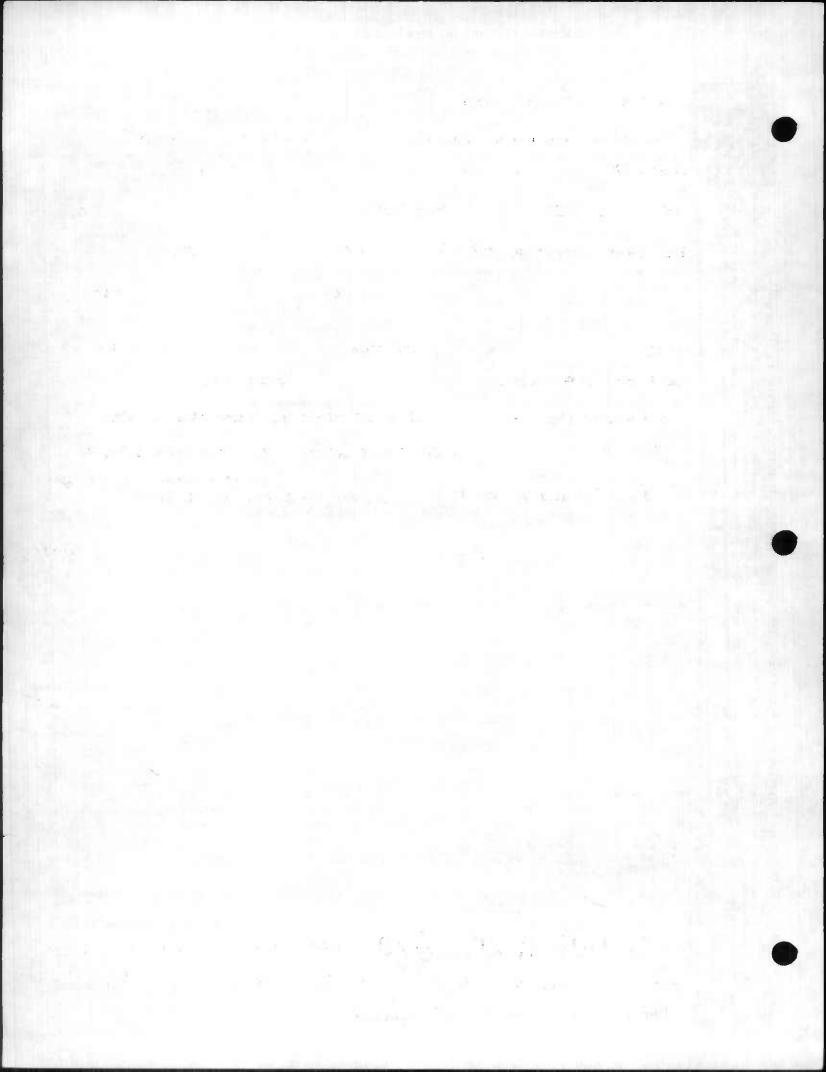


Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Maxine Virginia Goss March 11 2000 2147 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 102 Timber Ridge Drive Westminster Carroll Apt. 223 If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Oct 13 1916 5. Social Sacurity Number Birthplace (State or Foreign Country) 7. Age (in yrs. last birthday) Days Hours Min 1 M 2 F 220-05-3793 83 Yrs Md Director Usual Residence of Decedent the Marylend 10b. County r 28a-f show 10a. Stata 10c. City, Town or Location 10d. Insida City Limits Md Carroll Westminster 1 XYes 2 No Director 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ir than "natural", or items 23s or Apt 223 102 Timber Ridge Drive 21157 TISA Pages 1 and 2 should be filed within 72 hours after death neat of Heelth and Mental Hygiene.
Int: If item 27 is marked other than "natural", or Items 23.
Inty or other traumatic event, the leaded a factoring mainty or other traumatic event, the leaded a factoring mainty or other traumatic event, the leaded a factoring mainty or other traumatic event, the Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: g 3 ☐ Widowed 4 💆 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) waitress food service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Max Frederick Schumacher Stazel Stump 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Joan Dankert (friend) 6203 W. Hemlock Dr. Sykesville, Md 21784 20b. Place of Disposition (Nama of cemetery, crematory or other place)
Druid Ridge Cemetery 20c. Location - City or Town, Stata 20a. Method of Disposition permit. Pages
Depertment of
Important: If it
eny Injury or o 1 Burial 2 Cremation 3 Removal from Stata 3-14-2000 Pikesville, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Servica Licensee Haight Funeral Home & Chapel Page Haight Herbert P.O. Box 195 Sykesville, Md 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Physician tmmediate Cause (Final disease or condition resulting in death) /Medical ASCVD minutes Examiner Due to (or as e consequenca of) Examiner physicien and the burial-transit the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical that initiated avants resulting in death) Last Due to (or as a consequence of) attending p for use as signed by the a 23b. Did tobacco use contributa to the causa of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 1 Hinknown by 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an eutopsy performed? Completed certificate has b 1 Yes 2 10 No 1 Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Menne of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Certification: 1 Naturat 5 Pending Invastigation 1 TYes 2 No deeth. 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 3 efter 4 Thomicide i 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. edical 29a. Certifier within 24 hou To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of cartifia 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 295 Stoner live Suite 307 Westminster MD Herbert Henderson Jr MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

Registrar

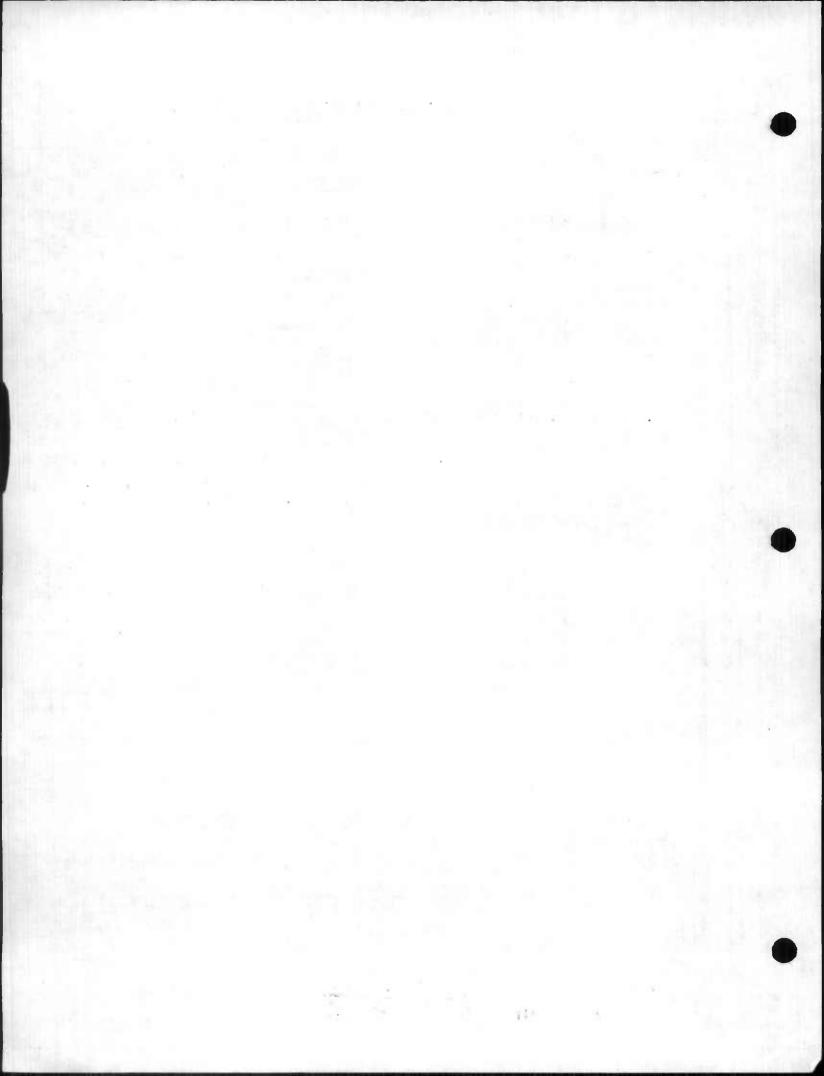
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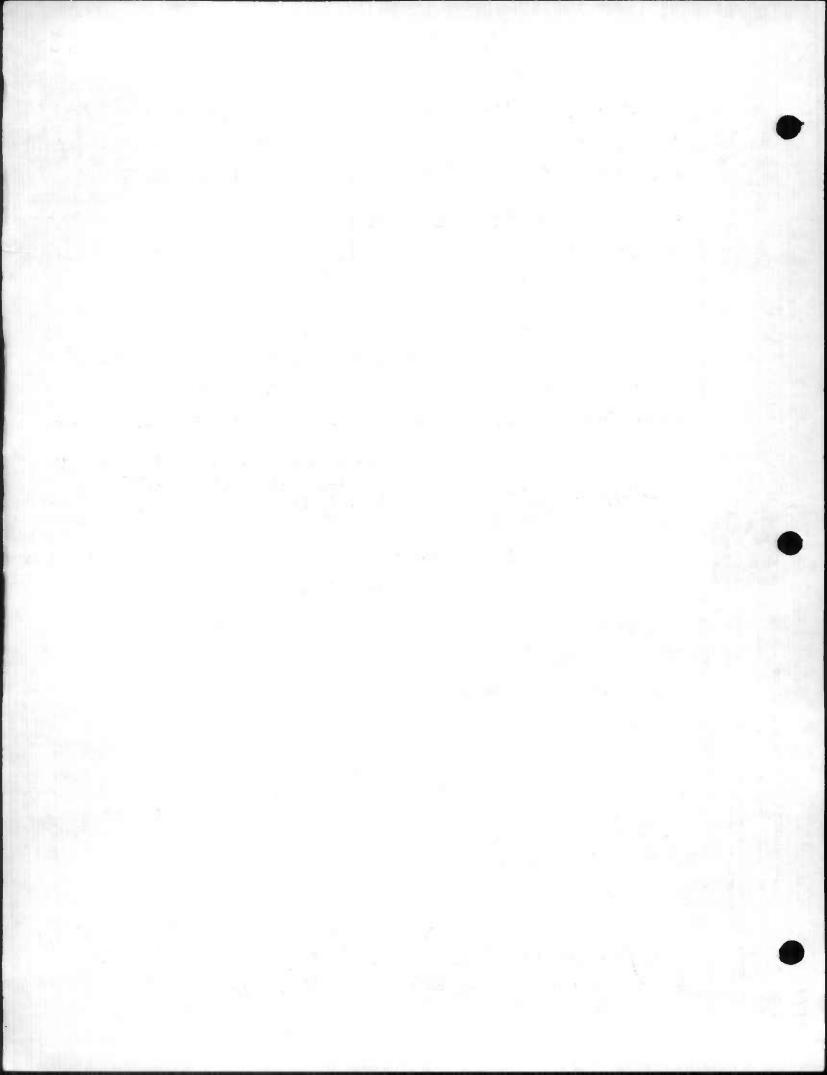
State of Maryland / Department of Health and Mental Hygien 086 | 5

			Certifi	icate of	Death		F	Reg. No.		
Physician	Decedent's Neme (First, Middle, La	George H.	Gut	h, Sr.			2. Dete of Dee Month	Dey 11, 200	Yeer	3. Time of Death 9:00 AM
/Medical Examiner	4a Facility Name (If not institution, given 2906 Page Drive	ve street end number)			4b. City, To		cation of Death	4c. County	of Death	
Funeral Director	5. Sociel Security Number 6. 5	Sex 7. Age (In yrs. less		Under 1 Year onths Deys			8. Dete of Birth (Month, De) July 2			re place (Stete or Foreign ntry) yland
with the Maryland a or 28a-f show Lbe notified at I Director	Usual Residence of Decedent 10a. State 10b. County Marvland Ba	10c City,	Town or Locatio		oundal	k				10d. Inside City Limits 1 ☐ Yes 2₺ No
er dosth with the Maryla thems 23a or 23a-f show the must be notified at uneeral Director	10e. Street and Number 2906 Page Drive		10	Of. Zip Code		1222		10g. Citizen of		
020 020 020 020 020	11. Meritel Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Detes: WWII	70.00	Decedent of I s, specify Cub Yes 2 12 No	tispanic Ori an, Mexican		ocify Yes or No- Rican, etc.)		ce - Americ ck, White,	an Indian,
1 21215-0020 ad within 72 hours at sypiens. ser than "nishural", or it, the Medical Exam Completed by I	15. Decedent's E (Specify only highest gro		16a. Decedent's	of work done	during mos	t of worki	ng	16b. Kind of B	usiness/în	dustry
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Vland Muld be file Mental Hyg mine event, To Be C	17. Father's Neme (First, Middle, Last Frank Guth)		3017	18. Mothe		(First, Middle,			
And 2 sho	19a. Informant's Neme/Reletionship Ms. Caroline R.	Type, Print) Guth (Daughter	19b. Meiling Ac							
altimore, N mit Pages 1 and portant: If Health portant: If Health y Injury or other Is	20e. Method of Disposition 1 Description 1 Company 1 Company	City or To								
K 68760, antificate be executed ing physician and e as the bunel-transit Medical Examiner Medical Examiner	Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a Due to (or a c.	792 Do not enter the	22 Wise mode of dyi	Ave.	Dur cardiac o		Marylan		Approximate Interval Between Onset and Death
dS, P.O. Boy ires that the death or signed by the attend d be detached for us d by Physician/	Pert II. Other significant conditions of	contributing to death but not resulti	ng in the under	lying cause gi	ven in Pert I					o the causs of death? bably 4 Unknown
0 > 100							24e. Wes	an autopsy med?	av	ere eutopsy findings alleble prior to impletion of cause deeth?
Vital Relacionario del							101	es 2 No	1[□Yes 2□No
Of Vita Physician: this certific ral director,	25. Wes case referred to medical examiner?	Hospital:		_ 0	nor:		(Check only o			
ion of \nding Physicath. The After this continue of funeral directions.	1 Yes 378-No 27. Menner of Deeth Neturel 5 Pending Accident Investigation	28a. Dete of Injury (Month, Day Year)	8b. Time of Injury	28c. Inju	4U NU		ne Page Resid	enca 6 Dotl		у)
Division of black of the control of	3 Suicide 6 Could not be determined	28e. Plece of Injury - At hom- building, etc. (Specify)	e, ferm, street, f	factory, office		2	28f. Location (5 City or Tox		ber or Rura	al Routa Number,
Division o To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:		ysician: To the best of my knowle niner: On the basis of examinetion and menner steled.								
To the within To the comp	29b. Signature end title of certifier	ella,		29c. Licens	se number	7/		29d. Date signe	1	Dey, Year)
6×1	30. Name and address of person who Dr. Thomas Folk				102	Pasa	idena, N	Marvlan	d	
State Registrar	31. Dete filed (Month, Dey, Year) MAR 1	32. Registrarts Signatur	0	. ,50	als	,	-	2		



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		A SHARE STATE			Certific	ate of	Death		Reg. No.		
ysician	ı	I. Decedent's Name (First, Middle, Las	st)	١,			Pt. 11 1	2. Date of De	eath Day	Year	3. Time of Death
ysician Medicai	ı	Dobby	Han	Kins				MARCH		000	8:45 P.S
aminer	4	e. Fecility Name (If not institution, give	e street end number)	- 1			4b. City, Town, o	or Location of Deat	h 4c. County	of Death	.)
	Į.	8044 High	5 Oak	Rd.				Burnia	Hon	P Arc	inde/
eral ctor	1	5. Social Security Number 6. S 2 1 7 - 4 6 - 286 2 1 Usual Residence of Decedent	ex 7. Age	(In yrs. last bir	Mont	nder 1 Year ths Days			y, Year)	9. Birthp Coun Virg	place (State or Foreign atry) 1n1a
14	-	10e. Stete 10b. County		10c. City, Tow	n or Location					1	0d. Inside City Limits
to		MD Anne A	rundel	Mi 11	ersvi	11e					1 ☐ Yes X☐ No
Funeral Director	1	Oe. Street and Number				Zip Code			10g. Citizen of	What Cour	ntry?
ral Director		8353 Elm Road				2110	8		USA		
iner in	1	1. Maritel Status	12. Was Decedent E Apped Forces?		13. Was De	ecedent of t	Hispanic Origin?	(Specify Yes or No erto Rican, etc.)	- 14. Rac	ce - Americ	
D A	•	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorcad	1 N Yes 2 No If Yes, Give Year or Dates:	1962/ 1965		s 2X No			Specify	v:	ite
Be Completed		15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a.	Decedent's U	Jsual Occup	pation during most of w	vorkina	16b. Kind of B	usiness/Inc	dustry
Idu		Elementery/Secondery (0-12)	College (1-4or 5-				ed)				
ပိ	-	12 7. Fether's Name (First, Middle, Last)		l D	esign	er	40 Mathada N	ame (First, Middle	Engi	neer	ing
any Injury or other treumetic event, the Medical once. To Be Completed	-	Elbert Hankins						oixie Mo	Gee		
The L		19e. Informant's Name/Relationship (1 Sharon Hankins /						Rural Route Numb			
and and	-	Oa. Method of Disposition	NICCC					, Glen	20c. Location		
0	1	1 ☐ Burial 2 ☐ Cremation 3 ☐		20b. Place of cemeter				1000			
	-	4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funerel Service Union		Metro	Crema	tory,	Inc. (3/11/00	Balt	imor	e, MD
DOC		Mames 12	eve		Crem	atio	n Soci	ety of	Maryla	nd,	Inc.
1	-	Thomas Greg	ØF		299	Fred	erick 1	Rd. Bal	timore	, MD	21228
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line	the death. Do r	not enter the r	node of dyi	ng, such as card	iac or respiratory a	rrest,	i	Approximete Interval Between Onset end Death
ian cal	1	immediate Cause (Final	1 2	0	- 1]	1 1 1
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Wedi	1	esulting in death) Last		00 10 101 00 0 0	onsequence .	01).					
an/Med			d								
Sicial Sicial	P	art ii. Other algnificant conditions co	entributing to death but	not resulting in	the underlying	ng cause gir	ven in Part I.	23b. Did	tobacco use co	ntribute to	the cause of death?
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by F	-							-			
should be								24a. Was	an autopsy	24b. We	ere eutopsy findings eileble prior to
NO	-							-		COI	mpletion of cause death?
Be Com								1 🗆	Yes 25 No	10	Yes 2 No
Be C	2	5. Was case referred to medical examiner?					26. Piece of D	eath (Check only	one)	Nie	celc
5 2		1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatien	t 2 ER/Ou	tpatient 3	DOA Ott	her: 4 Nursing	Home 5 ☐ Resi	dence 6 Oth	er (Specify	1 Home
	2	7. Manner of Death 1>S Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. T	ime of	28c. Inju	ry et rk?	28d. Describe	how injury occur	red	
at		2 ☐ Accident investigation			М	1 🗆	Yes 2□No				
Medical Certification:		3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injur building, etc.	y - At home, fa (Specify)	rm, street, fac	tory, office		28f. Location (City or To		er or Rura	l Route Number,
Ö											
cal	2	Check only 2 Medical Exam	sician: To the best of iner: On the basis of e	my knowledge	death occurr	red at the til	me, dete end ple	ce, and due to the	ceuse(s) end ma	anner as st	ated.
Med	-	one)	end manner state	ed.							
3	2	9b. Signature and title of certifier	1/2/	7-1		29c. Licens	se number	(-)	29d. Dete signe	d (Month,	Day, Year)
		Miny	(10)	Co	en	U)/5) /	March	- 11	,2000
	3	0. Name and address of person who o	ompleted cause of dea	affi (item 23a) (Type, Print)		11-1	0	10 11	R	101010
		1445861107076	Luce Mx	2 1600	12-((4)	High	way, Ste	WL, OH	M(nu,	W. M. M.
State	3	1. Dete filed (Month, Day, Year)	32. Registrar	s Signature	G	-			,		1.
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v 6/95					-	,					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Amended Item#27 perPHYG781 3/15/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month MARCH 3, 11:55 AM 2000 WILLIAM M. HADAWAY 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give straet and number) 4c. County of Death Baltimore 114 E. Eager Street 1st Flr If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 19, 1929 Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year 5. Soclei Security Number 6 Sax Months 1₽M 2□ F Deys 70 222-18-0242 Maryland Usual Residence of Daceden 10e Stete 10b County 10c. City, Town or Location 10d. Inside City Limits NO Yes 2□ No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21202 USA 114 W. Eager Street 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give' Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yas, specify Cuban, Maxican, Puerto Rican, etc.) 4. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) Cotlege (1-4or 5+) Jewelry/ Art Jeweler/Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Nama (First, Middle, Last) William Medford Hadaway Sarah Ann Jones 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 E. 34th St., Baltimore, MD 21218 198. Informent's Neme/Relationship (Type, Print) Mary Bond/friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 03/15/00 Baltimore, MD Metro Crematory, Inc. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee Chick Programme A. Gragorchik Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Daath Immediata Cause (Final ASCUR UNKADIM disaese or condition resulting in death) Due to (or es e consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or as a consequence of): Dua to (or as a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown CHEONE ATRIAL FUBRILLATION 24b. Were autopsy lindings available prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 Yas 2 No 25. Was case reterred to medical 26. Piece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Neturel 1 ☐ Yas 2 ☐ No 2 Accident ed could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece ol Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 - Homicide

P.O. Box 68760.

Physician

/Medical

Director

Funeral

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Completed

Be

Examiner

Funeral

Director

7 is marked other than "natural", or items 23s or 28a-f show treumstic event, the Modical Examiner man be notified at

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. important: If fem 27 is marked other than "nat any injury or other treumatic event, the Medical ORGS.

Physician /Medical

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Certification:

Medical

29a. Certifier

(Check only one)

the Maryland

death

Saltimore, Maryland 21215-0020

Division of Vital

ed by the a signed by t certificate this After death. after death Director: To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

> State Registrar

31. Dete filed (Month, Day, Year)

29b. Signeture and title of certifiar

RANDOURH GWHARES MO

Emdolph Whipos MD

30. Neme and eddress of person who completed cause of death (Item 23e) (Type, Print)

1 5 2000

827 LINDEN AVE BATTO. MD 21201

32. Registrer's Signature

1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

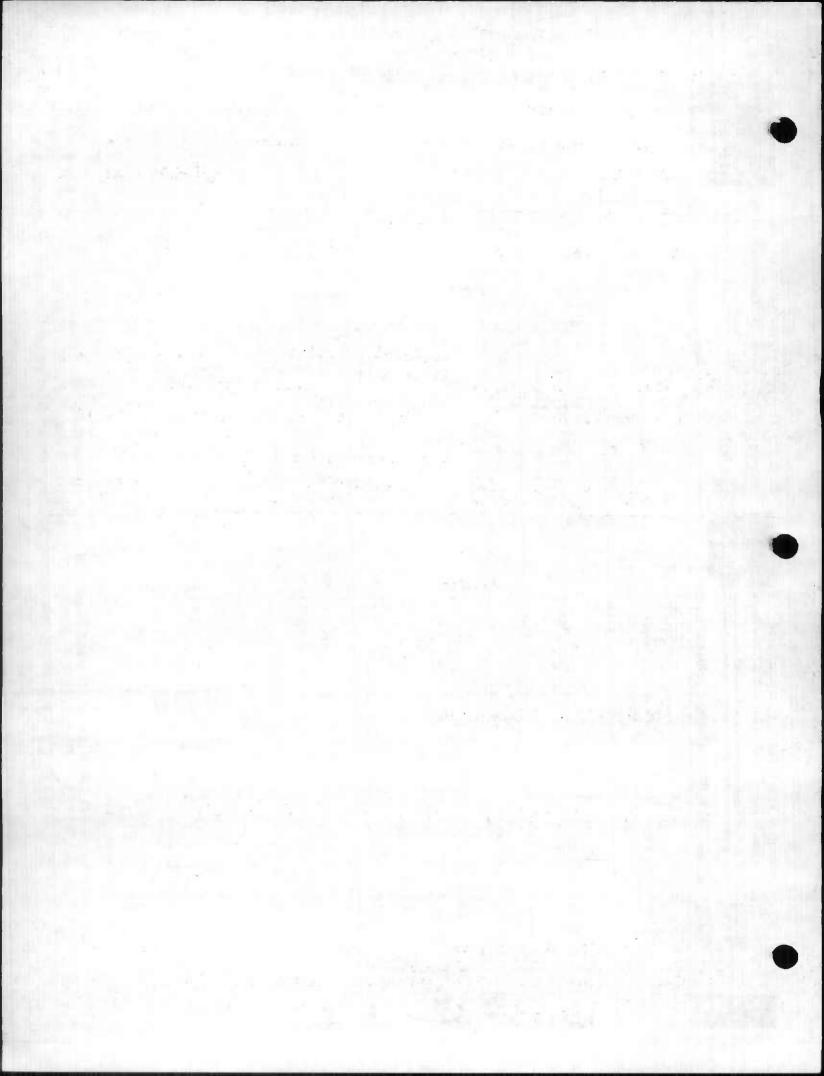
29c. License number

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29d. Data signed (Month, Day, Year)

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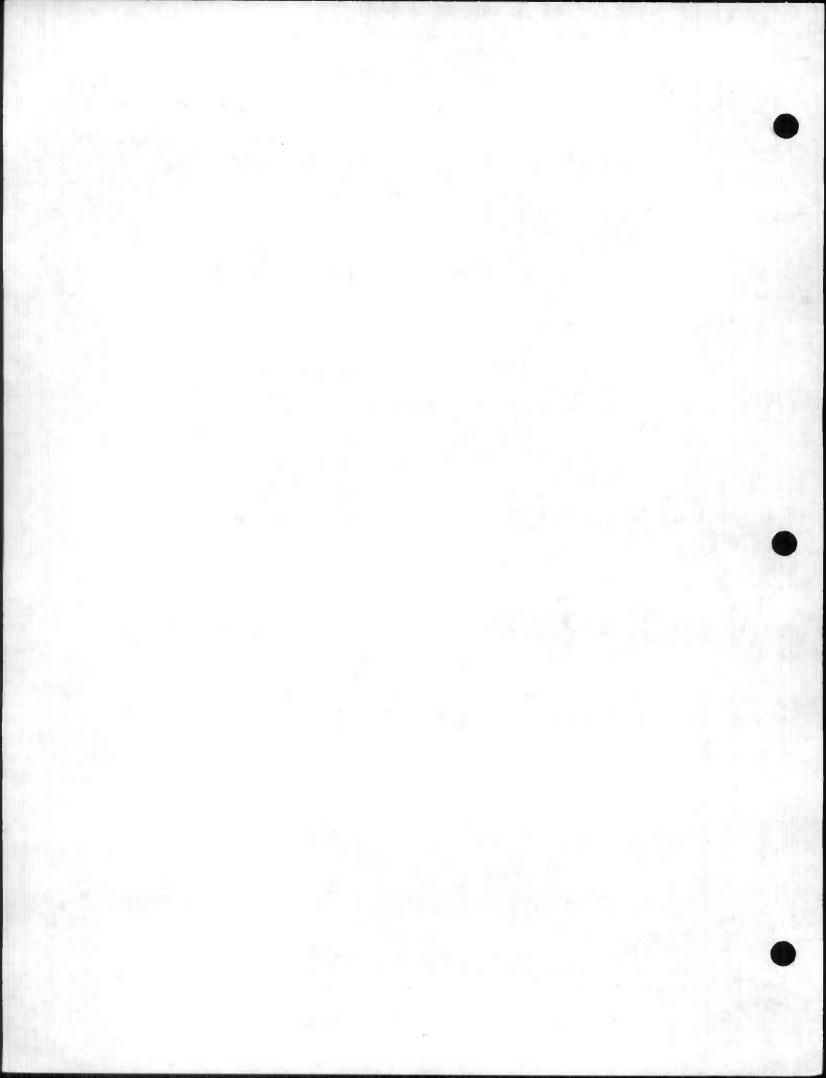
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State of Maryland / Department of Health and Mental Hygiene 00 08618

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lhucician	1. Decedent's Nama (First								2. Date of Dea Month	th Day	Yaar	3. Time of	Deat	
hysician /Medical	VA	LENT	INE	- 1	to PP.	4			March	-	000	10:1	5ar	
xaminer	4a Facility Nama (If not in:			ber)				4b. City, Town, or						
	326 Stillw					1 411		Esse			altimo			
eral tor	5. Social Security Number 213–30–0064		X XM 2□F	'. Aga (In yrs. 6		Month	ar 1 Yaa s Days			1934	9. Birthp Coun Ma1	laca (Stata d try) ryland	or Fore	
	Usual Rasidence of Deced	County		10c. Cit	y, Town or Lo	ocation	-				1	0d. Insida C	ity Lin	
Director	MD		Baltim					F	Ssex		1 ☐ Yes 2X an of Whet Country?			
	10a. Street and Number 326 Still	water 1	Road			101. 2	ip Coda	212		USA	A			
by Funeral	11. Marital Status 1 Nevar Married 2 3 Widowed 4 Di		12. Was Deced Armed Ford 1 XYes 2 If Yas, Give Year or Da	cas? 2 □ No		Was Dec If Yes, sp 1 ☐ Yas		Hispanic Origin? (S ban, Maxican, Puer Specify:	Puèrto Rican, etc.) Bla Speci			ace - Amarican Indian, ack, White, etc. ity: White		
Completed	15. De (Specify only	cedent's Edu	acation (a completed)		16a. Dece (Give	dant's Us	ual Occi	upation a during most of wo ed)	rking	16b. Kind of B	usinass/Ind	dustry		
g.	Elementery/Secondery (1	College (1-	4or 5+)				ed)						
	12th	elatin dana)			Ai	r Fo	rce	10 Mathada Na	rernme	ent				
Be	17. Father's Nama (First, M							18. Mother's Name (First, Middle, Maiden Surname) FRances Karcz						
2		cank H												
	19e. Informent's Name/Re					_			fumber or Rural Routa Number, City or Town, State, Zip Code) Pr Road Baltimore Md. 21221					
	Frances Ho		wife	201- 5										
	20a. Method of Disposition 1월 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) 20b. Place of Disposition (Nama of cematery, cramatory or other place) Oak Lawn Cemetery 3/16/2000 Baltimore Mc													
an	21. Signature of Funaral S R J 23a. Part1. Enter the disa shock, or heart failur	eru	1 (00	usad the deal	lu l	3	onne 00 M	rass of Facility 11y Funer Ace AVe. Ing. such as cardia	Baltimor	e Md. 2		Approximatintarval Bat Onset and	twee	
eal ner	Immediata Causa (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or injury that initiated evants rasulting in death) Last CARDIAC ARREST Dua to (or as a consequence of): Dua to (or as a consequence of): SIP CRESTRO VASCUAR ACCIDENT Dua to (or as a consequence of): HYPERTENS (ON)													
edical Examiner														
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iclan/N	Part II. Other algorificant o	23b. Dld 1	obacco uae co	ontribute to	The cause	of de								
by Physician/I		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I HUPGRUPIOIMA									23b. Did tobacco use contribute to the cause 1 ☐ Yes 2 ☐ No "3 ☐ Probably 4			
Completed b									24a. Was perlo	an autopsy med?	av	ara autopsy ailabla prior empletion of death?	to	
E O									101	ras 20 No	1[☐Yas 2□] No	
Be	25. Was case referred to	nedical	102 11					26. Pleca of De	ath (Check only o	na)				
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	27. Manne of Death 1 Naturat 5 2 Accident	Pending Invastigetion	28a. Dete o	f Injury n, Day Year)	28b. Tima o Injury	of M		ury at ork? □ Yas 2 □ No	28d. Dascribe	now injury occu	rred			
Certification:	3 Suicide 6 4 Homloida	Could not be determined	28e. Place o	of Injury - At h g, etc. (Specil	ome, ferm, st	reet, fect	ory, offic	ө	28f. Location (3 City or Tox	Street and Num vn, Stata)	ber or Rura	al Route Nur	n <i>ber</i> ,	
edical	29a. Cartifier 1 C C (Check only one)	ortifying Phy odical Exami	sician: To the tiner: On the ba	sis of axamine	owledga, deat etion end/or in	h occurre vestigati	ed et the on, in my	time, dete end pled opinion, deeth occ	e, and dua to tha urred at the time,	cause(s) end m date end place	nannar as s , and due to	statad. o the cause((s)	
Medica	29b. Signatura and titla of	certifiar		11		2	29c. Lica	nse number		29d. Date sign	ed (Month,	Day, Year)		
	Saba 30. Nama and addrass of		lchqu		10	Drieth		04/49.				-00)	
	5ABASI			5 Sten		R	un	Road	BALTO	, mo	212.	2/		
State	31. Data filed (Month, Day		32. Re	gistrar's Signa		4	1							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Deeth 3. Time of Death **Physician** 3:00 P.M 08 2000 HICKS JEORGE WASHINGTON MARCH · /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) 4c. County of Death Examiner 25 EAST PADONIA ROAD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth
Months | Davs | Hours | Min. | (Month, Day, Year) BALTIHORE Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 12M 20F Months FEB. 11, 1929 NORTH CAROLINA 220-20-1811 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Manylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23a or 28a-f show any intry or other traumatic event, its Mandles East income the notilities at 1 Yes 2 No IMONIUM Directo MARYLAND BALTIMORE 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 125 PADONIA ROAD EAST Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 (A Yes 2 □ No If Yes, Give Year or Dates: W W II 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: þ BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decadent's Education (Specify only highest grede completed) Elemantary/Secondary (0-12) Collega (1-4or 5+) MAINTENANCE ENGINEER PROPERTY MANAGERS UNKNOWN 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) Be (JERMAN KIZZIE HICKS SMITH 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) R) 125 EAST PADONIA RD. 71MONIUM, MD. 21093

20b. Place of Disposition (Name of cametery, cremetory or other place)

Date 20c. Location - City or Town, State (SISTER) MARY MARCUS 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) 4 Donation GARRISON FOREST 03-14-00 OWINGS MILLS, 21. Sign that of Funeral Service Lipersee

22. Name and Address of Facility

23. Name and Address of Facility

23. Name and Address of Facility

30. FULTON AVE., BALTIMORE, HD. 2/2/17

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest,

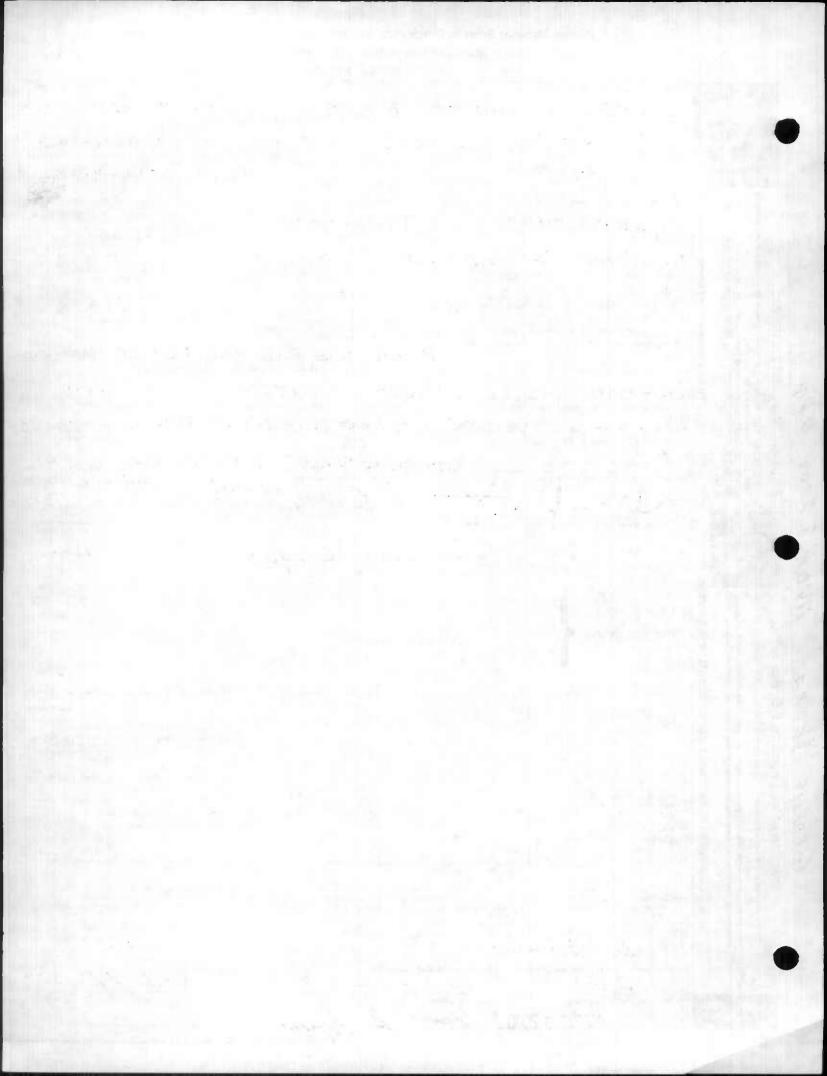
Approximate

Ap **Physician** /Medical Immediate Causa (Final Laugnx arcinoma disease or condition resulting in death) Examiner Examiner the attending physician and hed for use as the burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or Injury that Initioted events resulting in death) Last Due to (or as e consequence of): Physician/Medical Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part It, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 ₽ tinknown 1 | Yes 2 | No þ 24b. Were autopsy findings svailable prior to completion of cause of daath? 24a. Was an autopsy Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 10 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Panding 1 Yes 2 No Investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide or la after Hospital c 24 hours at Funeral D 1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and placa, and due to the cause(s) and manner es stated.
2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, data and placa, and due to the cause(s) and manner stated. 29a. Cartifias edical (Check only one) To the vithin 2 29d. Dete signed (Month, Day, Year) 29b. Signature and title of cartifier 29c. License number win mi 3-14-08 30. Name and address of person who completed cause of death (Itam 23a) (Type, Print) 828 N. Entain St. Ba Ho Md 21201 INCUINMO

Registrar

31. Dete filed (Month, Day, Yeer)

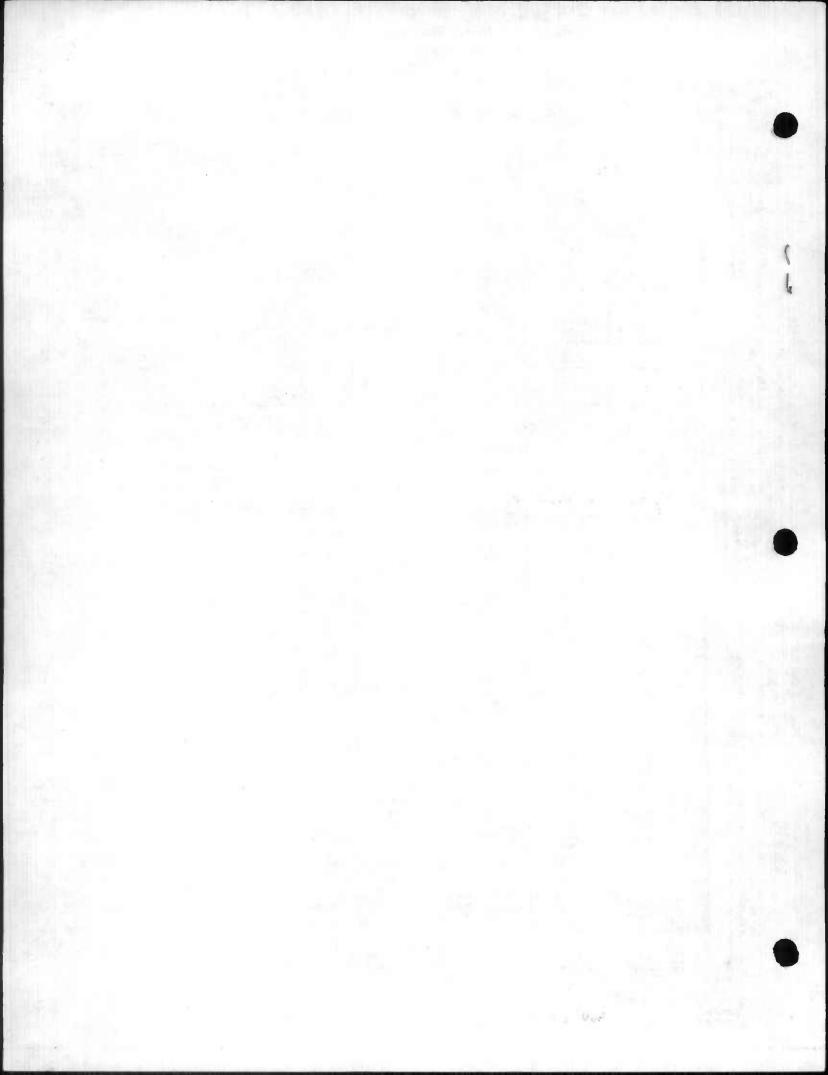
32. Ragistrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene \(\int \) \(\int \)

					Certific	ate of	Death		Reg. No.	00	01.0			
D 1		1. Decedent's Name (First, Middle, L	ast)					2. Dete of De Month	ath Dey	Year	3. Time of Death			
Physi /Med		Howard Leo Hoo	ok					March	00	00	10:05 an			
Exam		4a Fecility Neme (If not institution, g	ive street and number)			b. City, Town, o	or Location of Deat	4c. County	of Death				
		Greater Baltin		cal Cer			Towson		-	imore				
Funera Directo	_	212-20-0334	AXTHA OFF	ge (In yrs. last bir 69	Yrs. If Ur Mont	hs Deys	If Under 24 H Hours Mi		th y, Year) , 1930	9. Birthplace Country Mary	ca (State or Foreign Land			
pue *		Usual Residence of Decedent 10a. Stete 10b. County		10c. City, Tow	n or Location					10d	I. Inside City Limits			
e Maryl	ctor	Maryland Baltimo	ore	Balti							1☐Yes 2☐No			
or 28	Dire	10e. Street and Number				Zip Code			10g. Citizen of	What Country	n			
23 v	-	813 Templeclift	Road			21208			United					
21215-0020 d within 72 hours after death with the Manyland glene. or than "natural", or forms 23s or 28s-f ahow the Medical Examiner must be neutried at	by Funeral Director	11. Maritel Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Deceden Armed Forces 1 Tyes 2 K if Yes, Give Yeer or Detes:	t Ever in U,S. ? I No		s 200 No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	- 14. Rac Blac Specifi	e - American ck, Whita, ato Whit	С.			
15-002 72 hours "natural".	Completed	15. Decedent's I	Education	160	Decedent's U	Jsuel Occup	ation	vorkina	16b. Kind of B	usiness/Indus	stry			
T. S :	nple	Elementary/Secondary (0-12)	College (1-4or	5+)			during most of w	orning						
d 212 filled with Hyglene. ther ther		6th Grade	-0-		Shippi	ng Cl					trument Co			
Sega 2	Be	17. Father's Name (First, Middle, Las					18. Mother's Name (First, Middle, Maiden Sumeme) Margaret Angela Flynn							
aryian should be and Mental marked o	10	Helbert Reese I		106	Mailine Auto	State Zin C	Porto I							
20 4 4		Arthur Hook - I			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, 920 Olmstead Road; Baltimore, Maryland									
os 1 and of Health Ham 27 other tr		20a. Method of Disposition	22021102	20b. Place o cemete				Date	20c. Location					
0 00 - 7		1 Suriel 2 Cremation 3		9				115/2000	D.4 1	11 - W	1			
Baitimo permit. Page Department of Important: If any Injury or		4 Donetion 5 Other (Specify) Druid Ridge Cemetery 3/15/2000 Pikesville, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility												
Ba Pema	3													
		23a. Parti Enter the disease, or cor shock, or heart failure. List ont	nplications that cause		1 8 / 28 not entar the r	Liber mode of dyir	ty Road	; Randal iac or respiretory a	Istown,	A	pproximate			
Physician	, Н	shock, or heart failure. List only	y one cause on each	line.		1	_	(In	ntarval Batween Onset and Death			
/Medica		tmmediata Causa (Final	9	SANA	DA PIA	-11	ARCII	VOMA			1mis			
Examine	r	disease or condition resulting in death)	a	Dua to or as a	consequence			0 / 1 / /		1	11.42			
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Sian surial		Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury												
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X 6	Me		d											
BOX eath cert attendin	Physician/M													
the de	ysk	Pert II. Other significant conditions	contributing to death	but not resulting li	the underlying	ng cause giv	en in Pert I.	23b. Did	tobacco use co	ntributa to ti	he cause of death?			
det that								10	Yas 2□No	3 Probal	bly Dunknown			
ords, requires tracen signe should be	d by								an autopsy	24b. Were	autopsy findings			
	ete							perfo	rmed?	comp	able prior to pletion of cause ath?			
The law	Completed							10	Yas 2000	101				
Vitai I sician: Th certificata lirector, pa	Be	25. Was casa refarred to medicat					26 Place of C	eath (Check only			165 20160			
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		27. Manner of Death	28a. Date of tnj	ury 28b.	lima of	28c. tnjur Wor			how injury occur					
VISION Attending I r death. ector: Atter by the funar	atio	1 Natural 5 Pending 2 Accident investigation	on (Month, D	ly rear)	njury M		Yes 2 No	1.14.8						
Division of attending after death. I Director: Attending d in by the funs	Certification:	3 Suicide 6 Could not	28a. Placa of th	jury - At home, fe	rm, street, fac	ctory, office		28f. Location (City or To	Street and Numi	ber or Rural P	Route Number,			
D parage	Ce			io. (opcomy)			1							
Div To the Hospital or / within 24 hours after To the Funeral Dire completely filled in b	edicai	29e. Certifier Certifying P	hydiciao: To me best miner: Do the basis o	of my knowledge of examination en	, deeth occur	red at the tir	na, data end pta pinion, daath oc	ce, and dua to tha	causa(s) and made data end place.	annar as state	ed. na cause(s)			
To the P within 2. To the F complet	Med	()	and mannar s	tated.										
5.¥ 5.9		29b. Signature and title of continer	10000	- 11	1	29c. Licens	e number	7	29d. Dete signe	id (Month, De	iy, Year)			
		-april	June	141).	DU	1666	31	3/1	400				
10		30. Name and addrass of person with	completed causa of	daath (Itam 23a)	Type, Print)		4-14			/				
,		TB1	VIC 8											
S	tate	31. Date filed (Month, Dey, Year)	32. Regist	rer's Signeture	he	1								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Amended Item#12-14 perAB, Items#24a, 25, 26, 29a, 30 perPhy Gertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** 25, MARY HORCHLER FEBRUARY 2000 3:30 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Allegheny Nursing Home Cumberland Allegheny If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F Yrs. Director 214-07-2129 MD 90 July 25, 1909 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits "natural", or itema 23a or 28a-f show ad cal Examiner must be notified at 1 Yes 2 No Directo Cumberland Allegheny 10e. Street and Number 10f. Zlp Code 10g. Citizen of What Country? USA 21502 730 Furnance Street Fages 1 and 2 should be filed within 72 hours after death when the hold Mental Hygiene.

The file of the marked other than "natural" or flore 23 any or other traumatic event, the Medical Exercise many or other traumatic event, the Medical Exercise many. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 2 ☐ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, atc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 1 Naver Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 housewife none 18. Mother's Nama (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) John Clark Martha Petenbrink 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Box 421 HC86 Fort Ashby, WV Martha Kelso/daughter 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: If any injury or other 4X Donation - □ Other (Specify) 21. Signature of Fungare Segion Licenses de, Director State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 usse, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, re. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immadiate Cause (Final disease or condition resulting in death) Merhan Examiner Due to (or as a Physician/Medical Examiner eau he death certificate be executed physician end the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury Due to (or as a consequence of): that Initiated events resulting in death) Last Dua to (or as a consequenca of): 88 for use as contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the bed Part II. Other significant condition should be deteche 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy s certificate has b 1 Yes 2 No 1 □ Yas 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 🖾 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Dascribe how injury occurred

Box 68760, 0 di Division of Vital Records, Hospital or Attending Physician: funeral director, s after dec. To the Mospital or within 24 hours aft To the Funeral DI completely filled in

27. Manner of Death 1 Natural 2 Accident

3 ☐ Sulcide

29a. Certifier

4 Homicide

5 Pending Investigation

6 Could not be determined

28a. Date of Injury (Month, Dey Year)

28b. Time of 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify)

28c. Injury at Work?

1 Yes 2 No

281. Location (Street and Number or Rural Route Number, City or Town, State) 1 Cartifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and manner stated.

29b. Signeture and title of comit and an

29c. License number

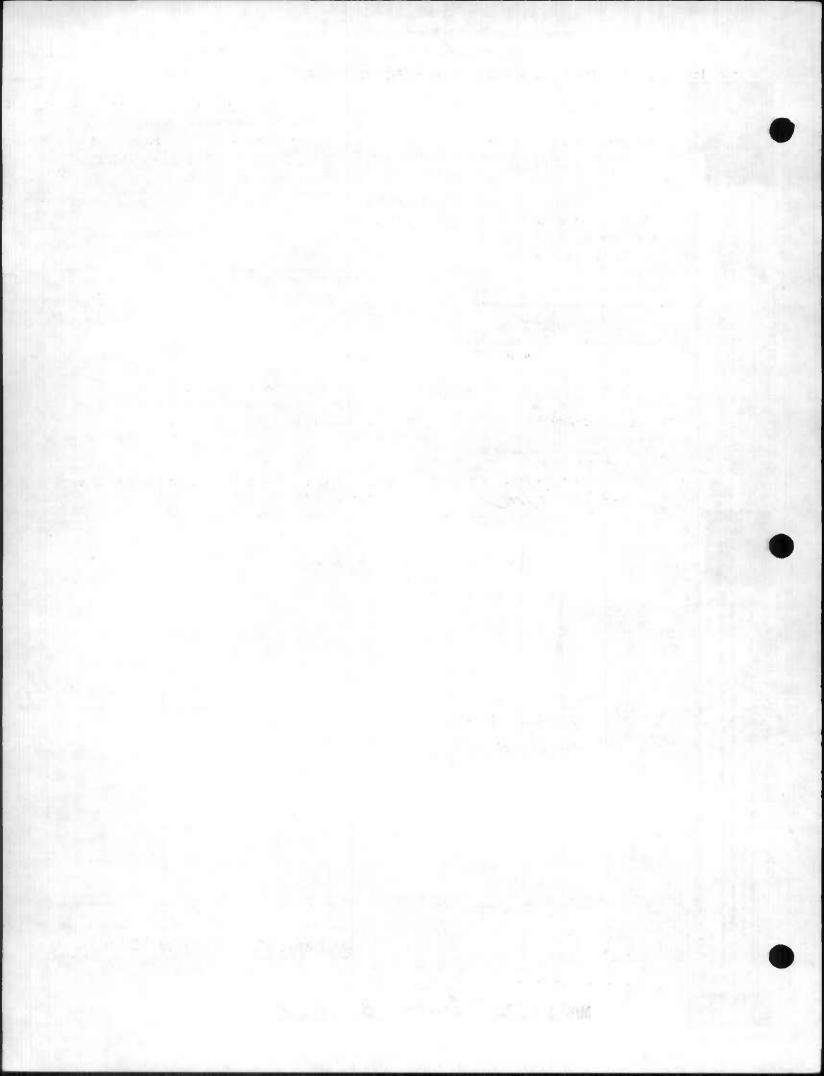
29d. Date signed (Month, Day, Year)

30. Name and address of person who, completed cause of death (Item 23a) (Type, Print)

V.A Rangithon 517 1 TOWN RD CUMBERLAND MD 31. Date filed (Month, Dey, Year)

State Registrar

Medical



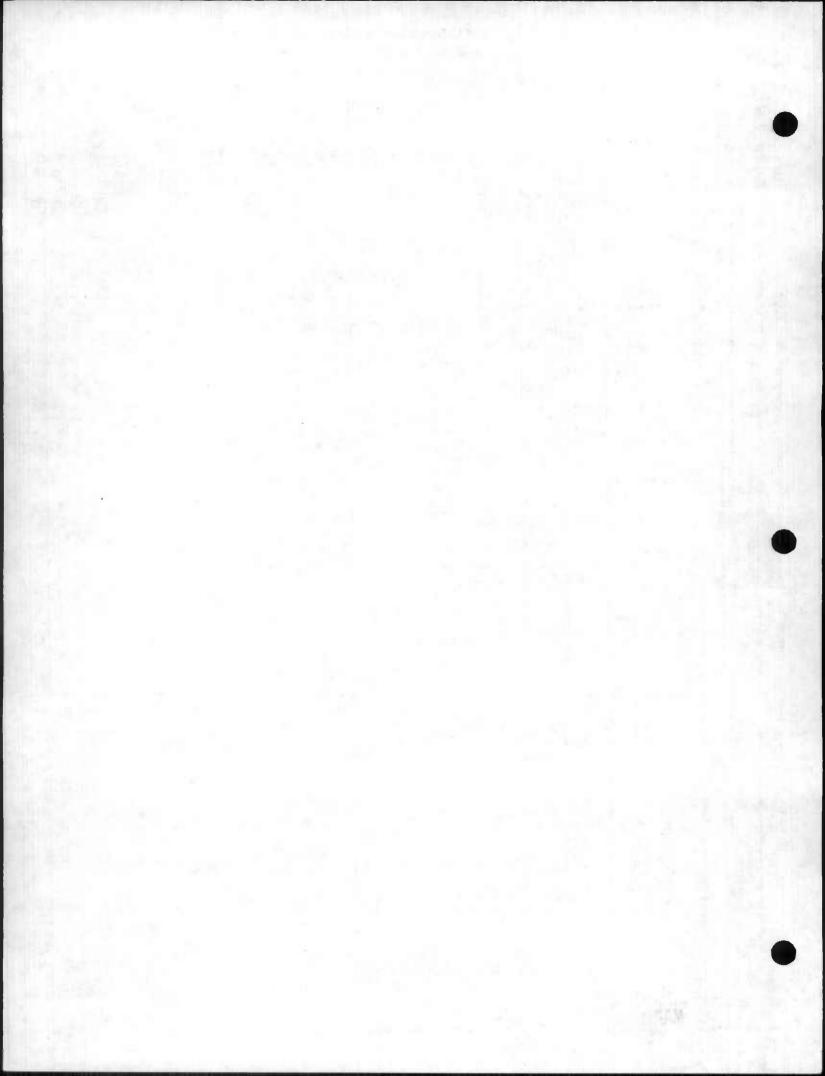
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State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Ri	g. No.	08622									
Physician	Decedent's Name (First, Middle, Last) MAD T.E. MA	2. Date of Death Month	h Day Yea	3. Time of Death									
/Medical	THEREST	MARCH	- 13-20	00 Ann.									
Examiner	4a Facility Neme (# not institution, give street and number) 4b. City, Town, or LEVINDALE HEBREW HOME BALTIMORI		4c. County of D	N/A									
Funeral	5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Yeer If Under 24 Hrs	8. Dete of Birth	9.1	Birthplace (State or Foreign Country)									
Director	055-09-0029A 10 M 212 92 Yrs. Months Days Hours Min.	OCT. 28,	1907	PA									
D .	Usuel Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location			10d. Inside City Limits									
fathor and		1⊠Yes 2□N											
or 28a-f a be notified	10e. Street and Number 10f. Zip Code	10	0g. Citizen of Whet	Country?									
		U.S.A.											
her death v r Herre 23s siner must	11. Marital Status 12. Wes Decedent Ever in U,S. 13. Was Decedent of Hispanic Origin? (S Armed Forces? If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	r No- 14. Race - American Indian, Black, White, etc.										
,	3 ☑ Widowed 4 ☐ Divorced Year or Dates:		WHITE										
ed within 72 ho ygiene. we then 'netur it, the Medical.	15. Decedent's Education 16a. Decedent's Usuel Occupation (Specify only highest grade completed) (Give kind of work done during most of work done	rking	16b. Kind of Busine	ss/Industry									
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and in the state of the state o		or Rural Route Number, City or Town, State, Zip Code)											
and 2 m 27 h	MARC LOWEN / SON-IN-LAW 6701 PARK HEIGHTS AVE	NUE #4-G	, BALTIM	ORE, MD 2121									
t of Harris or oth	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Dete	20c. Location - City or Town, State										
Part Hand	4 Donation 5 Other (Specify) MT. EDEN CEMETERY 3/14/00 MT/ PLEASANT, N												
Separate Sep	21. Signature of Eueral Service Lifensee 22. Name end Address of Fecility SOI	LEVINSO	N & BROS.	, INC.									
	8900 REISTERSTOWN												
	23a. Pert1. Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardial shock/or heart failure. List only one cause on each line.	or respiretory erre	est,	Approximate Interval Between Onset and Death									
Physician /Medical	Immediate Cause (Final disease or condition after myocardiel in turch on - thy												
Examiner	Due to (or as e consequence of):												
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ficate be executed physician and s the bunal-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that injured events.												
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ifficate be an g physician as the buria	that initiated events resulting in death) Last Due to (or as e consequence of):												
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d for	Part If. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of de-											
Attending Physician: The law requires that the death cer rideath. sctor: After this certificate has been signed by the attendint by the funeral director, page 2 should be detached for use fifcation: To Be Completed by Physician/A	Cerebrol maules accident.			Probably 4 Denknow									
gned be de	Cerebrel undles allident.												
v require been si should l		24a. Was er perform		b. Were autopsy findings available prior to									
law ras by 82 st				completion of cause of death?									
cate to pag		1□ Ye	s 2 D No	1 ☐ Yes 2 ☐ No									
ysician: The laving certificate has director, page 2	25. Was case referred to medical examiner? Hospital: Company of December 1	ath (Check only on											
Physic of rithis of rail dire	1 I Topatient 2 ER/Outpatient 3 DOA 4 Nursing F	lome 5 Reside	ow injury occurred	Specify)									
oding Fig.	1 Natural 5 Pending (Month, Day Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No												
	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (St. City or Town	reet and Number on, State)	r Rural Route Number,									
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
Mithin on the complete of the	29b. Signature and title of certifier 29c. License number	2	9d. Date signed (M	onth, Day, Year)									
	Meranima D44817	1	MARCI	4-13-2000									
1	30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)	0	. 1-	4-13-2000 Uhimose,									
S	Sunil P. Jayani 2434 W Jelus	dere a	ie, Iki	thimose,									
State	31. Date filed (Month, Day, Year) MAD 1 = 2000												

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Deeth Year Month Minnie Jensma 14, 2000 March 1:20 PM 4a Facility Neme (Il not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Eastpoint Nursing Center Baltimore Baltimore Hours Min. 8. Date of Birth (Month, Day, Year) FEB 8, 1917 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) Months Deys 10 M 70 F 83 479-22-6204 Yrs Iowa Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21224 1046 Old North Point Rd. USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 1 ☐ Yas 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 ♥ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) 12 Dietician Hospital 17. Fethar's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Johanna Van Vliet Tunis Hartgers 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) James Jensma/son 7830 Lockwood Rd., Baltimore, MD 21222 20b. Plece of Disposition (Neme of cemetery, cremetory or other pleca) 20a Method of Disposition Date 20c. Location - City or Town, Slete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Metro Crematory, Inc. 3/15/00 Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licente Cremation Society of Maryland, Inc. Edward A regorchik 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wera autopsy findings evailable prior to 24a. Wes en autopsy completion of cause of death? 1 Yes W No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical axaminer? 26. Placa of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 27. Menner of Deeth 28d. Describe how injury occurred 28c. Injury at Work? 1 Divetural
2 Accident 5 Pending invastigation 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a, Certifier

Division of Vital or Attanding Physician:

Jensma

Wilhelmina

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f ahow

ntal Hygiene. ed other than avant, the Me

. Peges 1 and 2 should be fit ment of Heelth and Mental Hant: If item 27 is marked off jury or other traumetic aver

Physician /Medical

Examiner

Physician/Medical Examiner

Completed by

Be

Medical Certification: To

filed within 72 hours efter death

21215-0020

Baltimore, Maryland

Director

Funeral

Completed

Be

within 24 hours after deeth.

To the Funeral Director: Al Hospital ş

State Registrar

DHMH 16 Rev 6/95

29b. Signatura and title of certifier

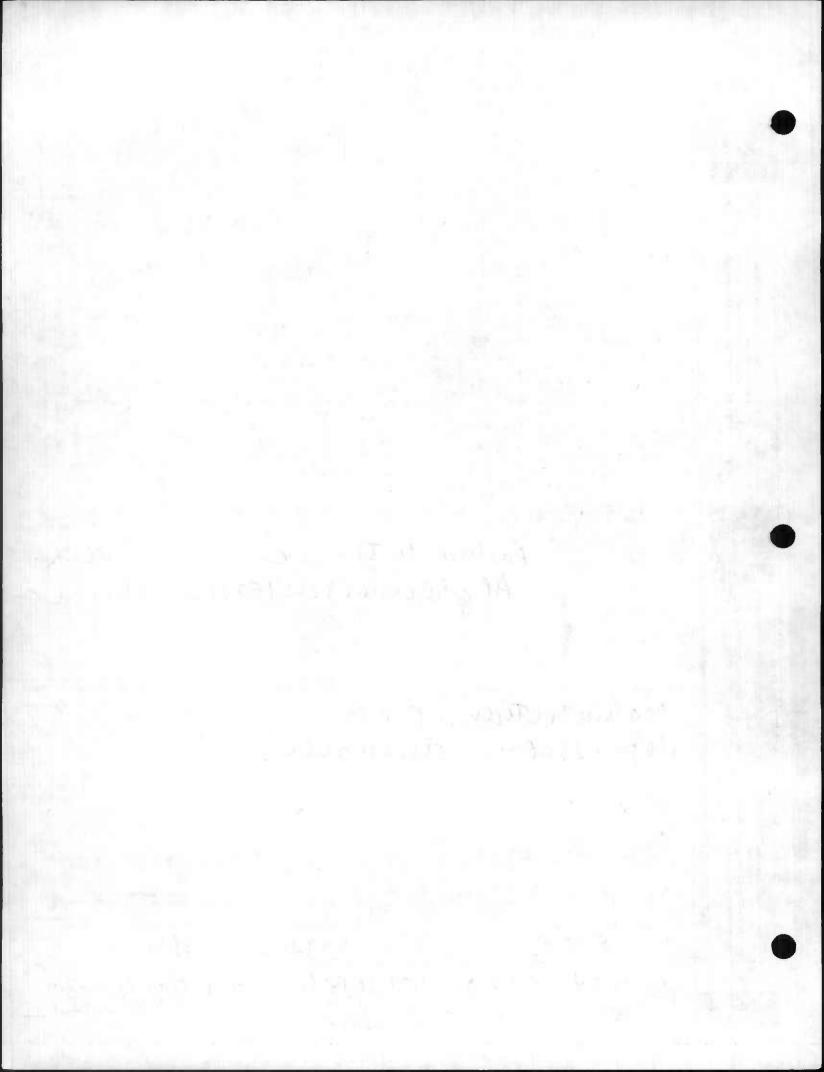
DA 31. Dete tiled (Month, Day, Year) MAR 15

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signeture

29c. License number

29d. Date signed (Month, Day, Year)



00-1429-510 cm

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

id / Department of Health and Ment	al Hygiene n	0	8	6	2
Certificate of Death	Ben No	U	U	U	6

rıa	Jeffr	ies		State of M	aryland /	Certifica:				ig. No.	081	524	
	Physic /Medi		1. Decedent's Neme (First, Middle, Li	JEFF	RIES				2. Date of Deat Month March	Day 200	Year	Time of Death : 18 A.M.	
	Exami		4e Facility Name (If not institution, given 2401 East Biddle	e street and number)			Ba	ity, Town, or Lo	cation of Death	4c. County			
	Funeral Director			Sex 7. Ag 1 □ M 2 🕱 F	ge (In yrs. last b	Yrs. If Unde Months		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, MAR. 14	Year) 1951	9. Birthplace Country)	(State or Foreign	
	Maryland of show fied at	tor	10a. Stele 10b. County		0	on or Location	E.		HA			nside City Limits ⊠ Yes 2□ No	
	th with the 25e or 28s ast be not	Funeral Director	10e. Street and Number 710 N. MAD	EIRA S		101. Zi		5	10	Og. Citizen of V	ten of White Country?		
020	ours after dea raff, or flams Examiner m	by	11. Maritel Stetus 12 Never Merried 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 25 If Yes, Give Year or Detes:		13. Was Dece If Yes, spe		nic Origin? (Spe exican, Puerto I ecity:	city Yes or No- Rican, etc.)		e - American In k, White, etc. B Ac		
21215-0020	d within 72 h giene. or then "netu st the Medical	To Be Completed	15. Decedent's E (Specify only highest gr.	ducation ade completed) College (1-4or	5+)	Decedent's Usu (Give kind of we life. DO NOT u	al Occupation ork done during se retired)	g most of workii	ng	NON			
Maryland	Mental Hy arked others	To Be	7	CF RIES			1	RUTH	(First, Middle, A	KSON	/		
100000	s 1 and 2 sh X Health and Nem 27 is m other traum		19a. Informent's Neme/Reletionship RUTH JEC- 20e. Method of Disposition	T-ERIES	20b. Place	Of Disposition (Na	MAD me of other place)	EIRAS	ST. BA	H70, /	2/ City or Town, 5	205 State	
Baltimore,	permit. Page Department: Important: if any injury or 2008.		1 Buriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specion 21. Signeture of Funeral Service Lice	nsee M. Col	ARBU Pes	TUS MGI.	nd Address of STAT	Facility FW	NERAL AVE B	SER	MO		
	Physician /Medical Examiner	ier	23a. Pert1. Enter the disease, or com- shock, or heart failure. List only Immediate Ceuse (Final disease or condition resulting in death)	a. Two g							trite	rval Between et and Death	
200	be axecuted ician and burial-transit	ai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury	b	Due to (or es e	consequence of):							
Box 68760,	nding physics as the	n/Medicai	that initieted events resulting in death) Lest	d	Due to (or es a	consequence of):					1		
P.O.	t the de	Physician/M	Pert II. Other algoliticant conditions of	contributing to death b	ut not resulting	in the underlying o	cause given in	Part I.	23b. Did to		ntribute to the	cause of death?	
Records,	aw requires is been sign 2 should be	Completed by							24a. Was a perform		availab	utopsy findings e prior to tion of cause 1?	
of Vital F	T sta	e Cor	25. Wes case referred to medical					St. 15 1		s 2 No	1,EYe	2 □ No	
>	yalclan: s certific director,	0	examiner?	Hospital:	20 500	utpatient 3 D	Othor		ne 5 Reside		or (Constitut 3)	t ccopo	
o uc	ling Ph	tion: To	27. Manner of Deeth 1 ☐ Neturei 5 ☐ Pending	28e. Dete of Inju (Month, De			28c. Injury at Work?	2	28d. Describe ho	w injury occur	be	L SCELLE	
Division	or Attendanted Director:	Certification:	2 Accident Suicide Sui						Subject was Shot 281. Location (Street and Number or Rural Route Number, City or Town, State) 2401 East Biddle Baltimere City, Manyland				
	4 hours	icai C		ysician: To the best onliner: On the basis of				ate and place, a	and due to the ca	use(s) and ma	nner as stated		

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (North 23a) (Type, Print)

Stephen S. Radentz, 111 Penn Street, Baltimore, Maryland 21201

State Registrar

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Jacob Market Mar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Deta of Death Month 16,2000 Baby Boy Johnson 9:30 a.m. January 4e. Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Sinai Hospital Baltimore City If Undar 1 Yaar | if Under 24 Hrs. | Months | Days | Hours | Min. | 5. Social Security Number 7. Age (In yrs. last birthday) Birthpleca (Stata or Foreign Country) 8. Data of Birth (Month, Day, Year) Days 1♥M 2□F Yrs 30 January 16,2000 Maryland Usuel Rasidance of Decedant 10b, Count 10c. City, Town or Location 10d. Insida City Limits 1 X Yas 2 No Maryland Baltimore City 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 2907 Allendale Road 21216 USA 12. Was Decedant Evar in U,S. Armed Forces? 13. Was Dacedant of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 ☐ Yes 2 X No If Yas, Giva Yaar or Datas: 1 X Navar Married 2 Married 1 ☐ Yas 2 X No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedent's Education (Spacify only highast greda complated) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) N/A 0 N/A 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nema (First, Middla, Maidan Sumema) David Wallace Taisha Sharnay Johnson 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Taisha S. Johnson - Mother 2907 Allendale Rd. Baltimore, MD 21216 20a. Mathod of Disposition 20b. Plece of Disposition (Nema of camatary, cramatory or other place) 20c. Location - City or Town, Stata 1 Buriel 2 Cramation 3 Removal from Stata 1-12 Baltimore City 4 □ Donation 5 X Othar (Specify) Hosp. Disp. Sinai Hospital 21. Signetura of Funarai Sarvice Licanseer 22. Nama end Addrass of Facility SIMAI HOS 23a. Perl 1. Enter the disaase, of complications that causad the death. Do not antar the mode of dying, such es cardiec or raspiratory arrest, shock, or heart failure. List only one cause on each line. Intervel Between Onset and Death Immediata Causa (Final disaesa or condition rasulting in deeth) Severe Immaturity Fetal Dua to (or as a consequence of): Sequentially list conditions, if any, laeding to immadiate cause. Enter Underlying Causa (Disaasa or Injury that initiated avants rasulting in death) Last Due to (or as a consequence of) Dua to (or es a consequenca of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an autopsy performed? 24b. Wara autopsy findings eveilebie prior to complation of cause of deeth?

Physician /Medical Examiner

physician

Physician

/Medical

Examiner

Director

Funeral

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Completed

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10a. Stata

Funeral

Director

the Manyland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Marylai Depentment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examples must be not fed.

Baltimore, Maryland 21215-0020

bunai-transit Physician/Medical the 8 for use signed by the at d be detached fo Completed by page 2 Be 10 Certification: filled in by the

Hospital or Attending Physician: The law requires that the death certificate be executed

certificate

this

After

after death

24 hours

To the

within 24 hor To the Fune completely fi

Medical

Box 68760.

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Division of Vital Records,

1 ☐ Yas 2 No 1 X Yas 2 □ No 25. Wes casa rafarred to medical axeminar? 26. Place of Daeth (Check only ona) Hospital: 1 X inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 27. Menner of Death 28b. Tima of Injury 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how Injury occurred 1 Natural 5 Pending 1 Yas 2 □ No invastigetion 2 Accident N/A N/A N/A 3 Sulcida 6 Could not ba 28a. Place of Injury - At homa, farm, straat, factory, office building, etc. (Specify) Location (Straat and Number or Rural Routa Number, City or Town, Stete) 4 Homleida 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, dete end place, and due to the cause(s) and manner as steted.

| Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signatura end titla of certifiar 29c. Licansa number 29d. Data signed (Month, Day, Year)

State Registrar

31. Data filed (Month, Day, Year) MAR 1 5 2000

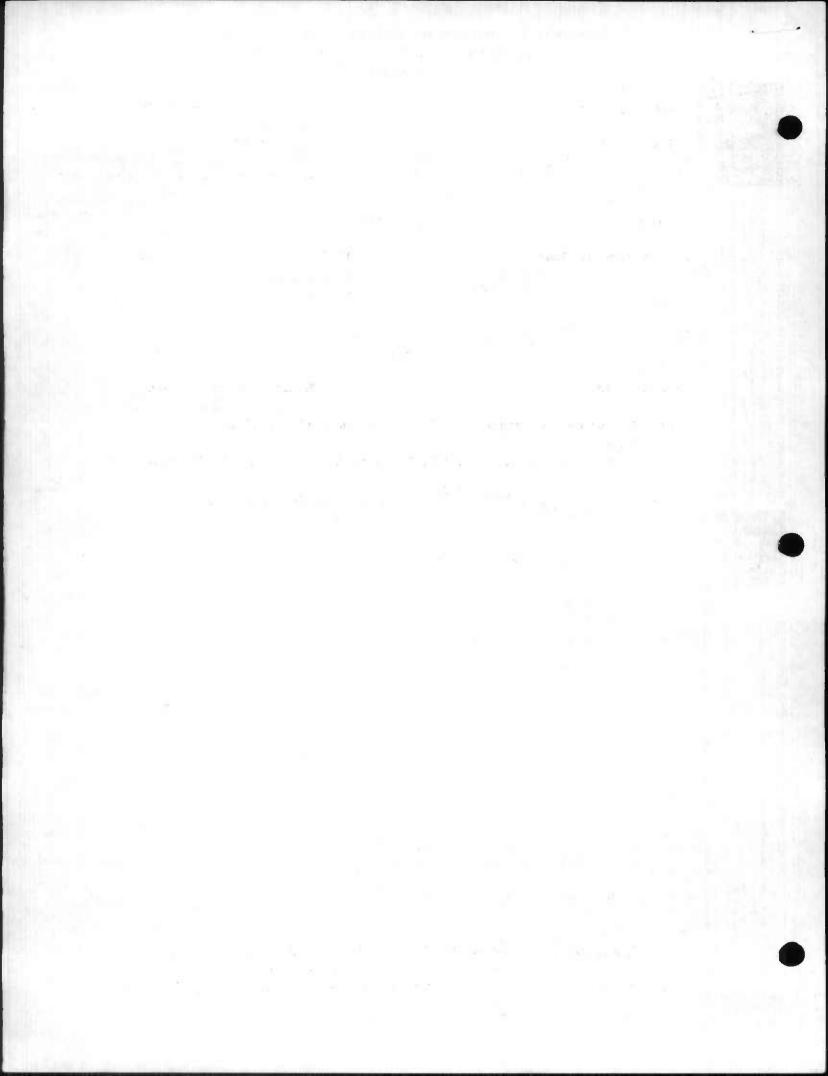
James Chisum, MD



30. Nema and addrass of person who complated causa of death (Item 23e) (Type, Print) Sinai Hospital

2401 W. Belvedere Ave. Balto., MD 21215

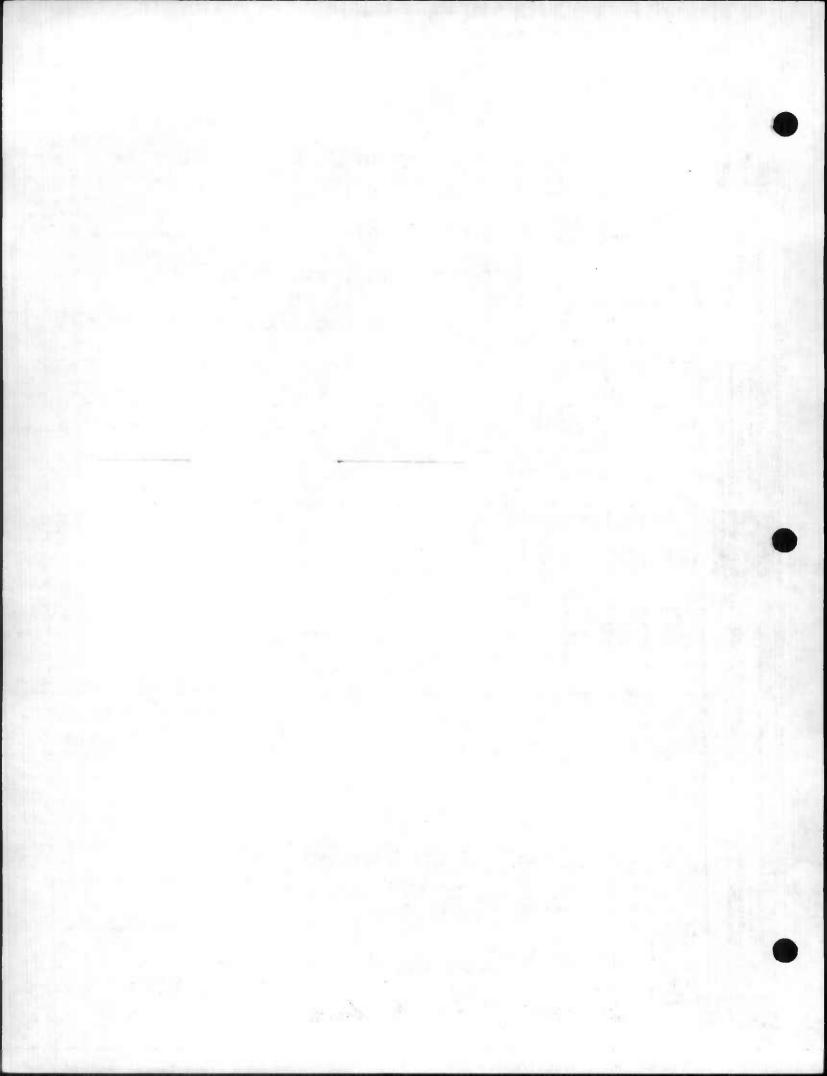
January 16, 2000



CS Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. 00-1436-005 State of Maryland / Department of Health and Mental Hygiene 08626 DERRICK JONES AMENDED ITEMS 20b & 20c PER FH G781 3/22/2000 AH Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dey Month Physician DERRICK D. JONES MARCH 12, 2000 13:30 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner I 795, northbound, north of Mt. Wilson MOUNT WILSON BALTIMORE 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6 Sex Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Day, Year) **Funeral** Months Deys 10 M 20 F Hours 213-02-4563 Director **Usual Residence of Deceder** the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ahow 1 Yes 2 No Director MD BALTIMORE GWYNN OAK 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21207 Norma 23a 6911 BROMPTON ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status be filed within 72 hours effer de htsi Hygiene. Ind other than "naturel", or flam avent, na Heden Eventual. Bleck, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: BLACK by 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) STUDENT 12-TH GRADE NA OCHOOL . Pages 1 and 2 should be filed iment of Health and Mental Hygic lant: If ham 27 is marked other fury or other traumatic avant, If 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) WALTER JONES KOBINSON DHARON 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) BROMPTON RD BALTO 21207 PHARON KOBINSON MOTHER 6911 MD. 20b. Place of Disposition (Neme of KING MEMORIAL PARK 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State RANDALLSTOWN, MD Department Department Important: If any injury or page. 03-18-00 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility VAUGHN C. GREENE FUNERAL SERVICE BALTO 5151 BALTO. NATL PIKE MO. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediata Cause (Final disease or condition resulting in death) HULTIPUS Dyvinos Examiner Due to (or as a consequence of) Examiner physician and s the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhibated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or es e consequence of): signed by the a d be detached i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? P.O. 1 Yas 2 No 3 Probably 4 Unknown Records. à 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed 1☐Yes 2☐ No of Vital 25. Was case referred to medical examiner? B 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6X Other (Specify) SCENE 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 Natural PASSEMEN IN CLAR, SOMEL BYTHING 1 Yes 2 No To the Hospital or Attendit within 24 hours after death. To the Funeral Director: All completely filled in by the fu 13:201M deeth. 3-12-00 2 NAccident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide ITATUS BAMMONTO MY pos mary 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie 29c. License number 29d. Dete signed (Month, Dey, Year) Moliprite O.C.M.E. MARCH 13, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4DR4D anso KORFU 111 Penn Street, Baltimore, Maryland 21201 Lew 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 5 2000 Jener Registrar DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 08627. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Death 2. Dete of Deeth Year Month Physician KozLoski 2000 00:25 AM CHESTER 13 MARCH /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE BALTIMORE GOOD SANARITAN HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) New York **Funeral** XDM 2DF Yrs. 199-09-5208 80 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No Directo or 28a-f York Fawn Grove 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 238 287 Deer Road 17321 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1943/ 1 Dives 2 No 1946 If Yes, Give 1946 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Merital Status 1 Never Married 2 Merried natural, or altimore, Maryland 21215-0020 1 ☐ Yes X ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Airplane Elementary/Secondary (0-12) College (1-4or 5+) Technical Illustrator Manufacturing 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surneme) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: 81 fem 27 is merised oth any Injury or other traumatic even once. Be Anthony Kozloski Valerie Luovinski 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Pollock/daughter 287 Deer Road Fawn Grove, PA 17321 20b. Place of Disposition (Name of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State Metro Crematory, Inc. 3/12/00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licens Cremation Society of Maryland, Inc. Thomas Gregor 299 Frederick Rd. Baltimore, MD 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or heart failure. List only one cause on sech line. Approximate Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SEPTIC SHOCK 24-364rs Examiner Due to (or as a consequence of): UROSEPSIS physician and the burlai-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): 3-4 days DEHYDRATION Box 68760. Physician/Medical Due to (or es a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ADENOCARCINOMA OF COLONS Records, 24b. Were autopsy findings available prior to completion of cause of daath? Completed 24a. Was an autopsy performed? PROSTATE CANCER 1 Yes 2 No 1 Yes 2 No Division of Vital e Hospital or Attending Physician; 24 hours after deeth. e Funeral Director; After this cartifloa istaly filled in by the funeral director, p. 80 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et tha time, data and place, and due to the cause(s) and manner steted. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) Scupta 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certified D0053150 HARCH 130 2000 BALTINORE 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) GUPTA, M.D. 5601 LOCH RAVEN BLVD, MD21239 SHAKUNMALA

DHMH 16 Rev 6/95

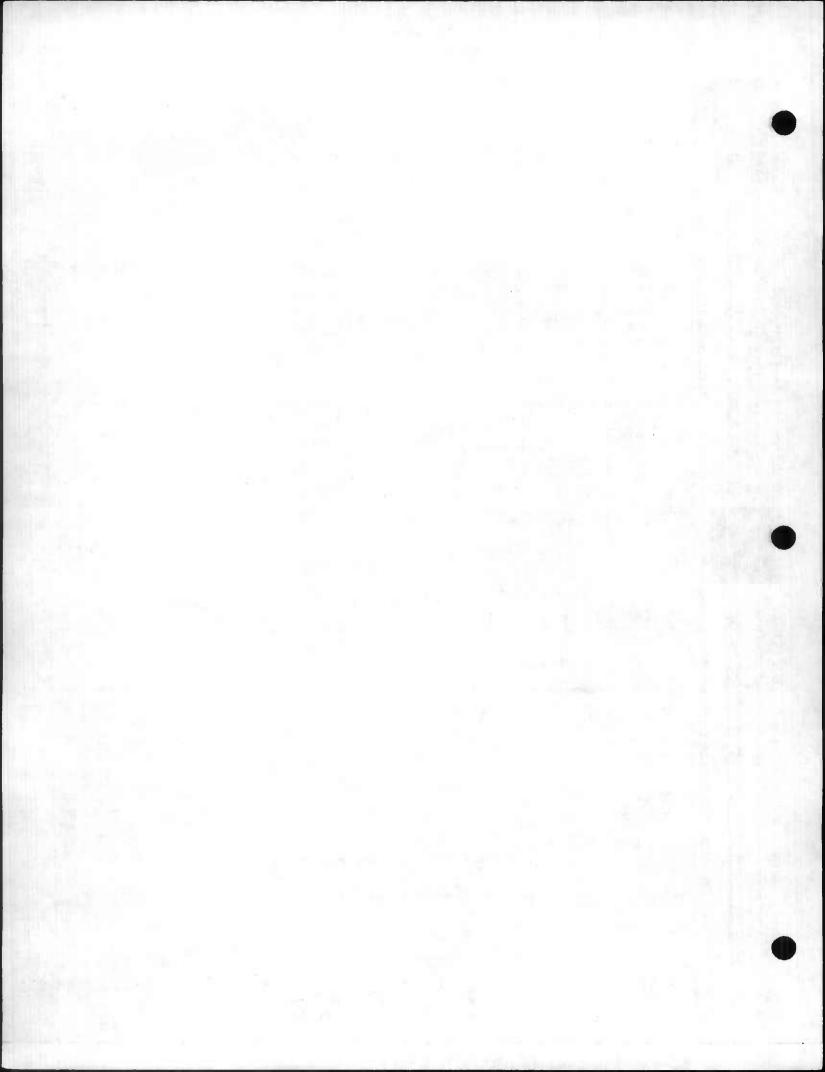
State

Registrar

31. Data filed (Month, Day, Year)

32. Registrii's Signature

MAR 15 2000 >



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year KRESS MARY 1245 PM 6. MAR 2000 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death VIEW MED. C+R-7. Age (In yrs. last birthday) If Under 1 Year BAYVIEW MED BALTIMORE If Under 24 Hrs. 8, Date of NA HOPKINS 5. Social Security Number Birthplace (State or Foreign Country) Months Hours 10 M 204F 218-14-0102 JUE 14, 192 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No BALTIMORE DUNDALK 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 454 HELENA AVE 21222 6558 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify. Specify: WHITE 3.≅Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8 th HOME MAKER HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) WALTER. A. Howe LOALIA C. GOODRICH 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6558 BASTO Mal ZIZZZ ST. HELENA MARGARET KRESS 20b. Place of Disposition (Name of cometery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Data 1 ☐ Burial 2 ☑Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTO. 100 Md. CREM. FUNERAL HOME, CHTO 22. Name and Address of Facility HARTLEY MILLER 21. Signature of Funeral Service Licensee Miller BALTO. 21234 HURFORD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final arrhythmia cardiac disease or condition resulting in death) Dua to (or as a consequence of) Heari Arteriosclerotic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) almonay ronic Obstructive Due to (or as e consequence of) Pulmonak Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Controlled riension 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Obesi adult anse 25. Was casa referred to medical examiner? 1 Ves 20 No 1 Yes 2 No 1 ☐ Yes 2 ☐ No Mous 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

1 Yes 2 No

Memitt

Tell Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

STUS

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29d. Date signed (Month, Day, Year)

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Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

Show

then "natural", or items 23s or 28s-f show the Medical Esseminar must be notified at

filed within 72 hours after

Hyglene.

permit. Peges 1 and 2 should be filed to Department of Health and Mental Hygle Important: If item 27 is marked other 1 any injury or other traumatic event, III

21215-0020

Maryland

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Physician/Medical

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Completed

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edical Certification: To

1 Natural

2 Accident

3 Suicide

29a, Certifier (Check only one)

4 Homlcide

29b. Signature and title of certifier

Robert

31. Date filed (Month, Day, Year) MAR 15

5 Pending

investigation

6 Could not be datamined

L.

or Attending Physician: After after death. Director: Aft tha

P.O. Records. of Vital Division

2 To the Hospital or within 24 hours aft To the Funeral Di completaly filled in

> State Registrar

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

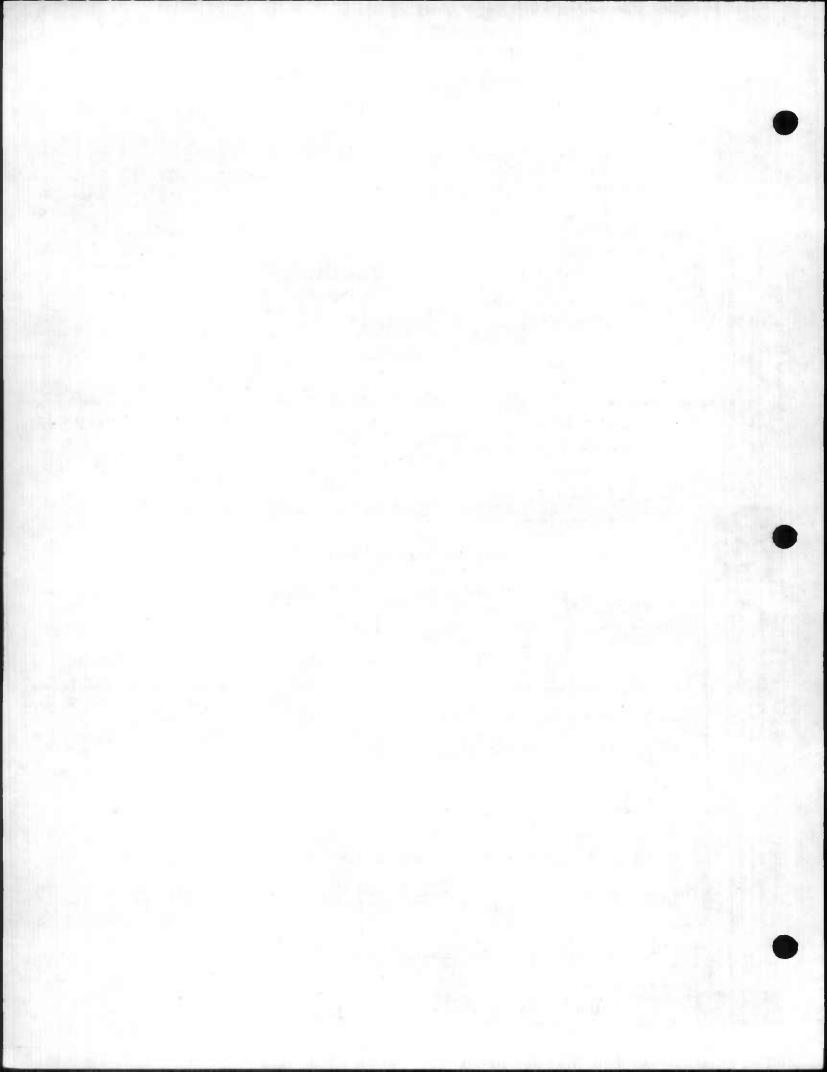
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Marcus, mo

2 Registrary Signature

Separe

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08629 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** KUPISCH KAREN 0606 MAR 2000 /Medical 4a Facility Neme (ff not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospital of Baltimore If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number ff Under 1 Yeer 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□M 2ØF 38 Karene, Kupish Director 219-70-9781 Dec. 30, 1961 Baltimore, Md. 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Manchester Md. Carroll 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 21102 U.S.A. 4729 Hanover Pike Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married "natural", or 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Se filed wit. *I Hyglene. *I the then ** Elementery/Secondery (0-12) College (1-4or 5+) 12 Registered Nurse Medical is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Peges 1 and 2 should be nent of Heelth end Mental Gayle E. (Williams) Fischer William M. Kupisch 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Neme/Reletionship (Type, Print) Department of Heelth e important: If Item 27 is any injury or other traphce. Gordon E. Fischer - step-father 1299 Naugahyde Road Westminster, Md. 21157 20b. Place of Disposition (Name of cametery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) March 18, 2000 Meadow Branch Cem. Westminster, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Eckhardt Funeral Chapel Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart tellure. List only one cause on each line. 21102 Manchester, Md. Approximate Intervat Between Onset and Death Physician /Medical Immediate Cause (Final . ACUTE MYDCARDIAL disease or condition resulting in deeth) **Examiner** Examiner Jaron sician and burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence ot) physician a Box 68760. Physician/Medical Due to (or as e consequence ot): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown MUNICIPA CASSAND LANGUARD CHUICA) Records. Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an eutopsy performed? RONAL IN WEICHNUM DEMYGUNATING POUSNEUROPATHY 1 Yes 1 Yes 2 No or Vital The Attending Physician: The Thours after death. Funeral Director: After this according to the Attending to the Attention of the At 2 No Division of Vital 25. Was case reterred to medicel axaminer? Be 26. Piace of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Dete of thjury (Month, Dey Year) 27. Menney ot Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of trijury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Funeral Domina of To the Funeral Domina on To the Funeral Domina on Total of 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end manner stated. 29e. Certifier (Check only one) 29b. Signature and title of cartified 29c. License number 29d. Date signed (Month, Dey, Year) 035085 3-14,00

State Registrar OM TTIVES URSA

MAR 15 2000

31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

32. Registrar - Signeture

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

ALAN LATT MD, KARNAN HOSTITAL, ZZDOKANAN DRIVE) BACTMINE, MD ZIZOZ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08630 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Data of Death 3. Tima of Death Month **Physician** aves apr /Medical 4c. County of Deal 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner more If Under 24 Hrs. 8. Dete of Birth (Manth, Dey, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplaca (State or Foreign **Funeral** 10 M 20 F Days 217-16-332 Months Hours anc Director Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits 28a-f show Examiner must be notified at 1 Yas 2 No Director land nore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 8 238 Funeral ol 04 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No MYes, Give Year or Dates: items : 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indien, 11. Marital Status permit. Pages 1 end 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item eny injury or other traumatic event, the Medical Example Black, Whita, etc. 1 Never Merried 2 Married 1□ Yes 2 No Specify: þ 3 \ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 20Ue 0 17. Fether's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be rave 198, Informant's Neme/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other p 20e. Method of Disposition Dete 20c. Location - City or Town, Stata tery, crematory or other place) 1 Burial 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) enmoun remator 22. Name and Address of Facility JOSEPH L. KU 2222 W. Nort 21. Signature of Funeral Service Dicenses era W. North Aue. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In deeth) /Medical Examiner Due to (or es a consequence of): Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial Physician/Medical Due to (or es a consequence of): igned by the atter Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Completed by 24a. Wes an autopsy performed? 24b. Were eutopsy findings eveilable prior to completion of cause of death? has 22 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 30 DOA After this 27. Menger of Deeth 1 Netural 28b. Time of Injury 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. tnjury et Work? 5 Pending To the Hospital or Attending with Et hours after death. To the Funeral Director: After completely filled in by the for 1 Yes 2 No investigetion 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Illed in by 4 Homicide edical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signad (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

the Manyand

death

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed

Box 68760

P.O.

Division of Vital Records.

or Attending Physician:

000 32. Registrar's Signature

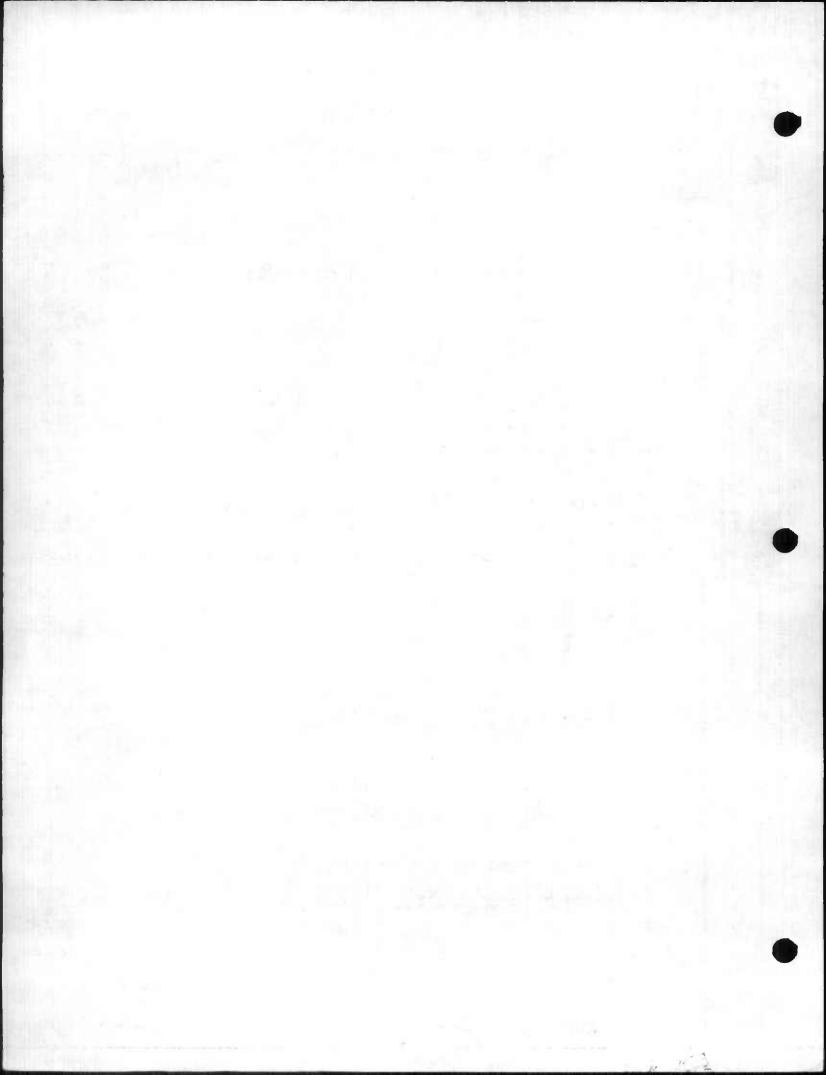
30. Neme and address of purson who completed cause of death (Item 23a) (Type, Print)

10/th

31. Dete filed (Month, Dey, Year)

ORIGINAL

2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 3. Tima of Desth 2. Dete of Death **Physician** Katherine Sue Kirkner 13, 2000 4:25 PM Mar /Medical 4b. City, Town, or Location of Death 4a Fecility Nama (If not institution, giva street end number) 4c. County of Deeth **Examiner** 3026 Bird View Rd. Carroll Westminster If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In vrs. last birthdev) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2CKF Yrs. 54 217-78-7477 Director May 10, 1955 Virginia Usual Rasidence of Decedant permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or frems 23s or 28s-f show any lidury or other traumatic event, the Medical Exactles in a larger and any lidury or other traumatic event, the Medical Exactles in a larger and any lidury or other traumatic event, the Medical Exactles in a larger and any lidury or other traumatic event, the Medical Exactles in a larger and any lidury or other traumatic event, the Medical Exactles in a larger and any lidury or other traumatic event. 10a Stete 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 ☐ Yes 2 🖾 No Maryland Carrol1 Westminster Directo 10e. Street and Numbar 10f. Zip Coda 10g. Citizen of What Country? 3026 Bird View Rd. 21157 Funeral United States 12. Was Decedent Ever in U,S. Armad Forcas? 1 ☐ Yes 2 ☐ No If Yes, Giva Yaar or Datas: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, etc.) Race - American Indien, Black, Whita, atc. 1 TX Nevar Married 2 ☐ Merried 1 Yas 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada complated) Etamantary/Secondary (0-12) Cotlege (1-4or 5+) Physically Handicapped NA 18. Mothar's Nama (First, Middle, Maiden Sumame) 17. Fathar's Nama (First, Middla, Last) Albert Landis Kirkner Merle Davis 19a. Informant's Name/Ralationship (Type, Print) 19b. Maiting Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 3026 Bird View Rd. Westminster, MD 21157 Albert Kirkner (Father) 20b. Place of Disposition (Name of cematary, cramatory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Date 1 ☑ Buriai 2 ☐ Cramation 3 ☐ Ramoval from Stata Providence Calvary UMC Cem. 3/17/00 Finksburg, MD 4 Donation 5 Othar (Spacify) 21. Signatura of Funeral Service Lice 22. Nama and Addrass of Facility Burrier-Queen Funeral Directors, P.A. 1212 West Old Liberty Rd. Winfield, MD 23a. Pari1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or haart failure. List only one cause on each line. Approximata Intervai Batwaan Onsat end Death **Physician** /Medical Immediata Causa (Finat diseasa or condition rasulting in daath) ENCEPHOLOMALACIA WITH Examiner PROGRESSIVE NEU POLOGIC GETERIURBIJON Examiner physician and the burial-transit Sequentially list conditions, if any, laading to Immadiata ceusa. Entar Undarfying Causa (Diseasa or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): 88 attending p for use as 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 1 Yes 2 No 3 Probably 4 Unknown py 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was cesa rafarred to medical axaminar? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) 1 Yas 2 No Certification: To 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? 1 🖾 Naturat 5 Panding 1 ☐ Yas 2 ☐ No 110 Investigation 2 Accidant Place of trijury - At homa, farm, streat, factory, office building, etc. (Specify) 6 Could not be determined 3 Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. 29a, Certifier edical (Check only one)

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. signed by the a bluods is certificate has director, page 2 The or Attending Physician: this After thi death. after death Director: A Funeral Di hours a npletaly within 24 h To the Fun To the

the Maryland

Baltimore, Maryland 21215-0020

State Registrar

29b. Signature and title of cedalies

32. Registrar's Signature

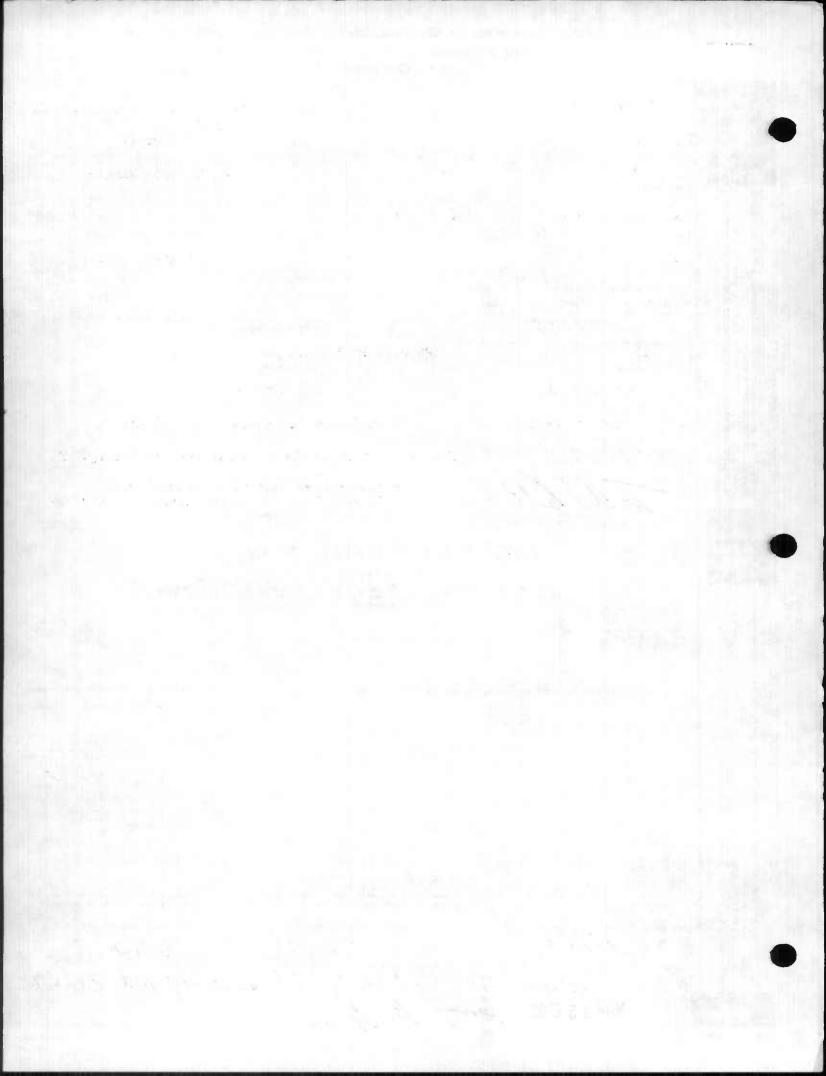
30. Name and address of person who comptated ceusa of death (tram 23a), (Type, Print)

2000

iberty Rd. Eldersburg Md. 21784

29c. Licansa number

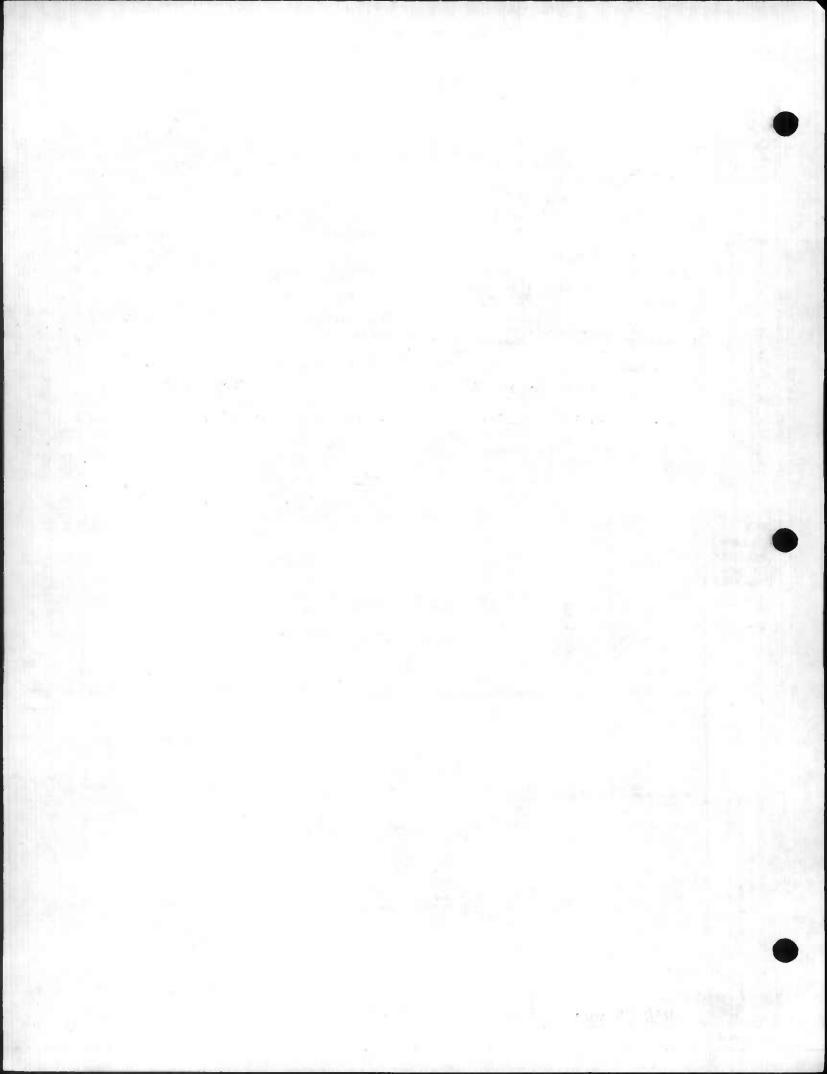
29d. Data signed (Month, Day, Year)



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State of Maryland / Department of Health and Mental Hygiene 00 08632

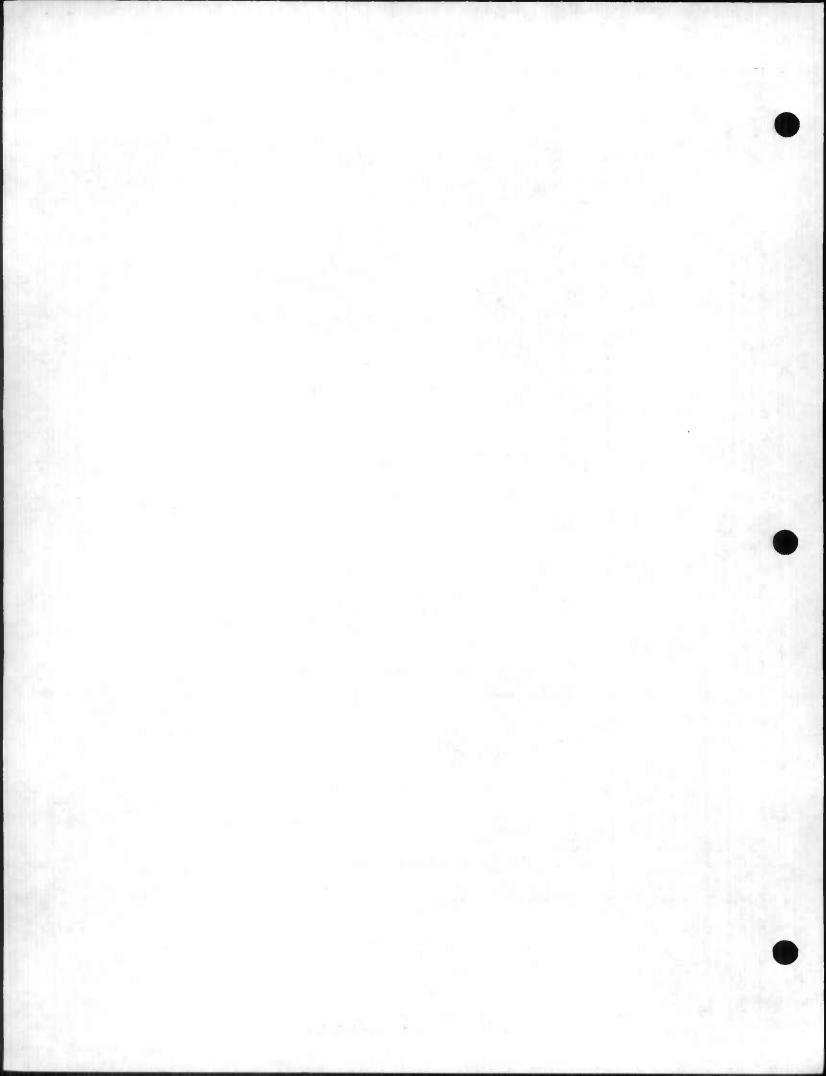
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	20a. Method of Disposition 1 ⊠ Burial 2 □ Cremetion 3 □ 4 □ Donation 5 □ Other (Specif)		20b. Plece of I cemetery Oak La	, crematory o	r other pi		Dete 2000	20c. Location		wn, Slele Maryland	
Department of Important: If I seny injury or DOSS.	21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility Duda-Ruck Funeral Home of Dundalk, Ir. 7922 Wise Ave. Dundalk, Maryland 21									nc. 1222	
edical Examiner	timediate Cause (Finel disease or condition resulting in death) a. Acute Pulmonary Edema Due to (or es e consequence of): b. Myacardial Infarction Due to (or as e consequence of): Due to (or as e consequence of): Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of):								1	2 Days	
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al Cert	4 Homicide determined	28e. Place of Inju- building, etc	. (Specify)					own, State)	anner as st	teted.	
Medical	(Check only ane) 2 Medicat Example 29b. Signature and title of certifier	iner: On the basis of and menner sta	examinetion and	or investigati	on, in my	opinion, deeth or	courred at the time	, date and place, 29d. Date signe	and due to	the cause(s)	
) male	MD			RD	192658		march			
	Dr Madal CHA		eath (Item 23a) (TOO) Fran	ype, Print) Klin	Squ	are Dri	ve Balti	more m	Da	1937	
State	31. Date filed (Month, Day, Year)	32. Registra	r's Signature	loan 4	/						



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

ED ITEM #22 P	ER FH G781 3/15/2000		f Maryland			of Health a of Death	nd Menta		ene 0	0 (08633
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	5161 TALBOTS	LANDING				ELLICO		Y	HOU	UARD	
Funeral Director	5. Social Security Number 215-18-6777 Usual Residence of Decedent	6. Sex 1 □ M 2 □ F	7. Age (In yrs. Ia	Yrs.	If Under 1 Y Months D	Yeer If Undar 2 Peys Hours		ta of Birth onth, Dey, Y	23	9. Birthpl Coun	lace (State or Foreign try)
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cat	2 Accident Invest	igation not be	11.1		М	1 Yes 2 1		eastics (O)	at and at = :	2015	I Pouts Mark
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	30. Name and address of person	who completed ceus	e of death (Item	23a) (Type, P			1222			. 5	9
State	31. Dete filed (Month, Dey, Year		agistrar's Signet	07	, -,						
State egistrar	31. Dete filed (Month, Dey, Year MAR 1	5 2000	Geneva	· 1.	do	2. 1.					

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08634 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dey Physician Month Margaret Dorsey Kaltenbach March 13,2000 6:50 P.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Hospice Of Baltimore, Gilchrist Center Towson 7. Age (tn yrs. last birthdey) If Under 1 Year Montha Days 5. Social Security Number If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 12-10-1910 9. Birthplece (Stete or Foreign Country) Maryland **Funeral** Days 1 ☐ M -282 F Hours 89 Director 217-09-7074 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Towson 10f. Zip Code 10e Street and Number 10g. Citizen of Whet Country? 8203 Carrbridge Circle 21204 U. S. A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give 21215-0020 1 Yes 2 No Specify: Specity: White 3 Widowed 4 ☐ Divorced Year or Dates KALTENBACH 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Own Home Homemaker 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumerne) 2 should be fi and Mental F Be James McFee Dorsey Mary Louise Kemp 19b. Meiling Address (Street and Number or Rurat Route Number, City or Town, State, Zip Code) 19e. Informant's Neme/Reletionship (Type, Print) Item 27 Mrs Phyllis DuVal (Daughter) 10 Patchwork Court, Monkton, Maryland 21111 Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Loudon Park Cemetery 3-16-00 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. Wallace S-Brooke, J 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final MASSIVE STOKE weeks disease or condition resulting in deeth) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieled events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760, Physician/Medical the Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records, þ 2 24b. Were eutopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes an eutopsy performed? 281 No 1 Yes 1 Yes 2 No certificate of Vital or Attending Physician: 25. Wes case referred to medicat 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? After Division 1 Natural 5 Pending Investigation safter death. 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital or within 24 hours aft To the Funers! Di completely filled is Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) end menner es stated. Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. edicai 29a. Certifier 29c. License number 29b. Signeture and Infa 29d. Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Dey/Year)

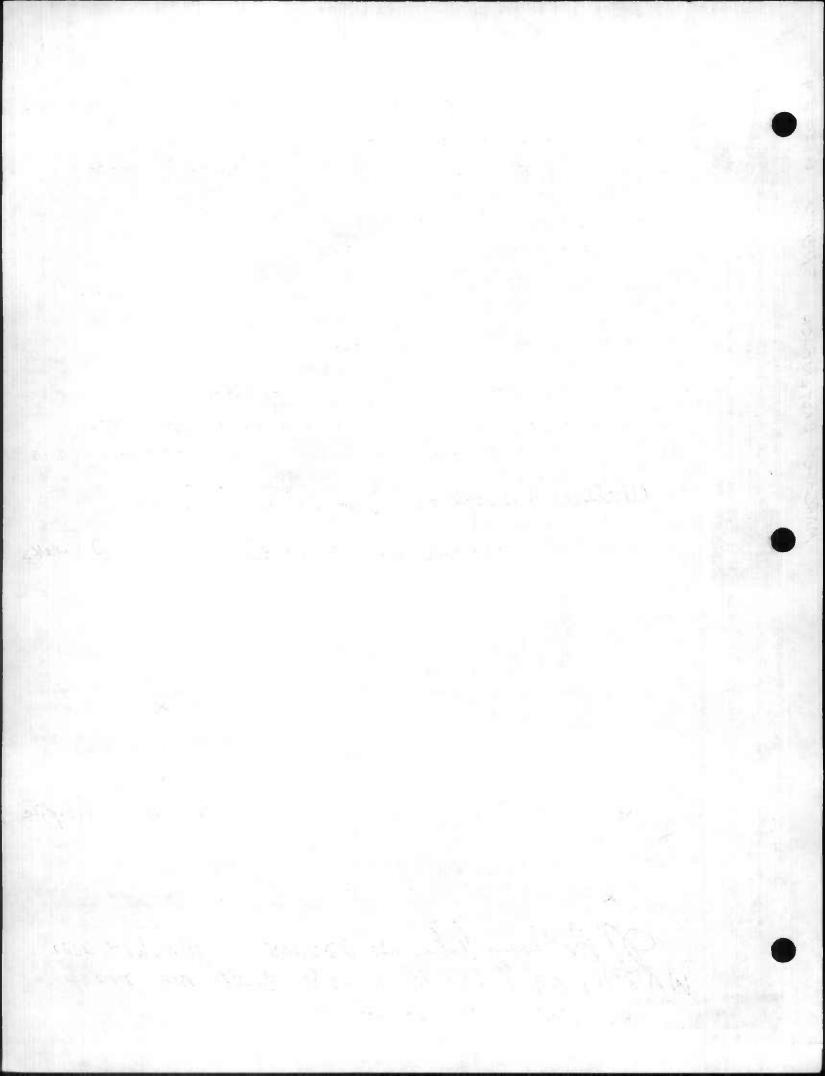
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MARCARET

Charles S7, Balto, md

e of deeth (Item 23a) (Type, Print)

6701 32. Registrer's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death CHARLES LINK IR. **Physician** 0155 MARCH 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Northwest Hospital Center Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Dete of Birth (Month, Days Hours | Min. (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 220-20-6515 Director Feb. 10, 1928 Baltimore, Md. Usuel Residence of Decedant 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Md. Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 134 Wilgate Road 21117 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Stetus permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" any injury or other traumatic avance. Black, White, etc. 1 Never Married 2 Married 1 Tyes 2 1946-47 If Yes, Give 1946-47 Year or Detes: Specify: White 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondery (0-12) College (1-4or 5+) Optometrist Vision/Eye 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Charles Joseph Link Mary Feiler 19a. informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernadine Mary Link - wife 134 Wilgate Road Owings Mills, Md. 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetary, crematory or other plece) Date 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal from Stete Maryland Veterans Cem. March 17, 2000 Owings Mills, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name end Address of Facility Eckhardt Funeral Chapel Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, or heart feiture. List only one cause on each line. Md. 21117 Approximate Interval Batween Onset and Deeth **Physician** CARDIOPULMONARY /Medical immediete Ceuse (Final diseese or condition resulting in death) Examiner Due to (or as e consequence of) Examiner ASCUD Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): ANGINA Physician/Medical Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown by 24b. Wara sutopsy findings svailable prior to completion of cause of death? Completed 24e. Wes an autopsy performed? 1 Yas 2 No 25. Was case referred to medical examiner? 1 Yes 2 No Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Other (Specify) Certification: To 1 Inpatient 2€ ER/Outpatient 3□ DOA 28a. Dete of Injury (Month, Day Year) 27. Manper of Deeth 28b. Time of 28c. injury st Work? 28d. Describe how injury occurred 1 Naturel 5 Pending investigation 1 TYes 2 No 2 Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) 4 Homlcide

Iclan and burial-transit physician a 56x 68760. signed by the a Records, certificate Division of Vital this After Attending s after death. ò

Hospital 24 hours

Within 2 \$

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29a. Cartifier 1 🗹 Certifying Physician: To tha best of my knowledge, daeth occurred et the time, date end place, and due to tha causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and dua to the cause(s) end menner steted.

(Check only one)

29b. Signeture end titla of certifier

29c. License number HOOS 1339 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARLAN Novthwest Hospital Guter 5401 Old Ct. Rd. Randallstown, mg

4.2000

State

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Registrar **DHMH 16 Rev 6/95**

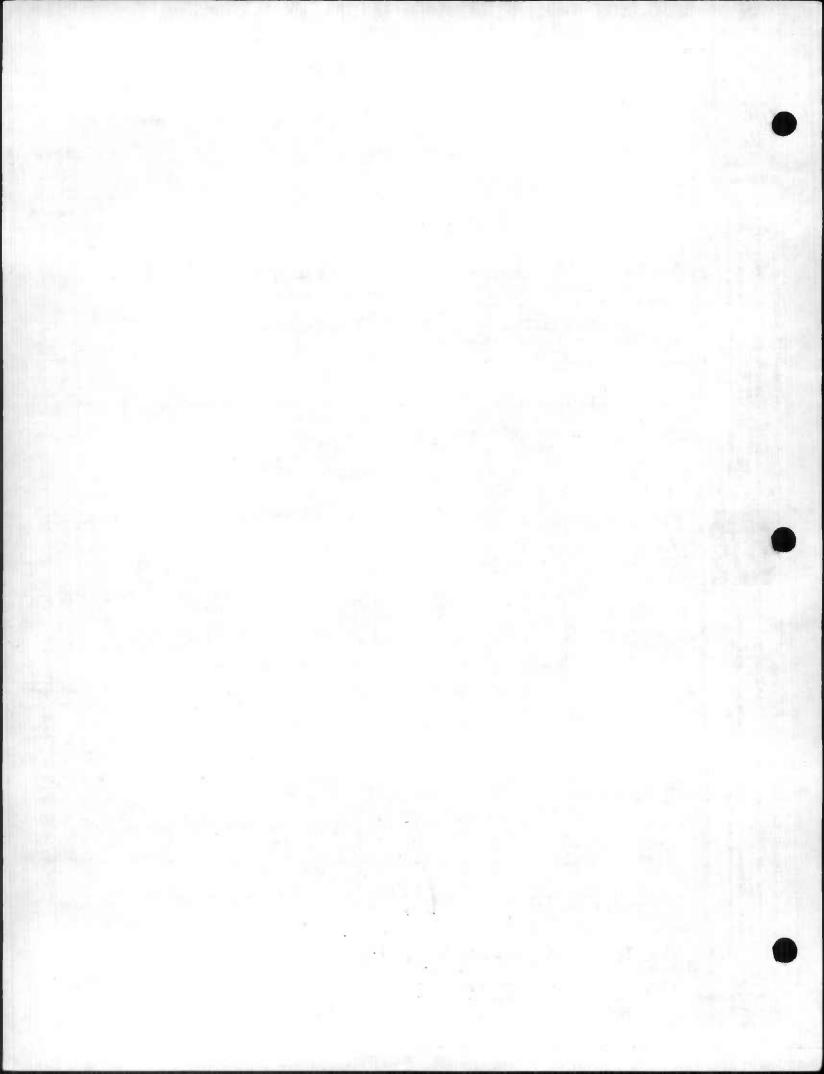
32. Register's Signature

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ian D. McC	EMS: #23 PART I, II, 27 PER MI	land / Departm E0 G78 Certific	ate of L	Death		leg. No.	000	536		
Physician	1. Decedent's Neme (First, Middle, Last) Lillian Dale McCarthy				2. Date of Dea Month	Day	Year	ime of Death		
/Medical	4e Facility Neme (tf not institution, give street and number)			lb. City, Town, or L		11, 2000 4c. County		49 am		
Examiner	4233 Newport Avenue			Baltimor		N/A	Or Doubl			
Funeral	5. Sociel Security Number 6. Sex 7. Age (tn	yro. mot birtirouy	der 1 Year	If Under 24 Hrs.	8 Date of Birth	1	9. Birthplace (State or Foreign		
Director	212-28-5280 1DM \$QF 6	3 Yrs. Mont	hs Days	Hours Min.	NOV 10,	1936	Maryla	and		
2	Usual Residence of Decedent 10e. State 10b. County 10c	: City, Town or Location					10d. fns	side City Limits		
Maryla 4 short led at		altimore					_	Yes 2 No		
villi the Ma or 28a-f a be notified	10e. Street and Number		Zip Code			10g. Citizen of V	What Country?			
th with the Mary 23e or 28e-f sh unt be notified.	4233 Newport Avenue		2121	11		USA				
her death v r lisens 23s siner must. Funeral	11. Meritel Stetus 12. Wes Decedent Ever Armed Forces?	in U,S. 13. Was De	cedent of Hi specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No-	14. Rac Blac	e - American Ind k, White, etc.	ian,		
Emmin by Fu	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Detes:		s 210 No			Specify	7.71- 2 4	e		
	3 U Widowed 4 U Divorced Yeer or Detes: 15. Decedent's Education	16a. Decedent's U	Isual Occupi	ation		16b. Kind of Bu	usiness/Industry			
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To B	George Hand Fowler				lian B					
7 is m traum	19a. Informent's Neme/Reletionship (Type, Print) Joseph P. McCarthy/husba	• McCarthy/husband 4233 Newport Ave. Baltimore, MD 21211								
other tr		0b. Plece of Disposition (Name of	!	Date		City or Town, St			
707	1 Burial 2 XCremetion 3 Removel from State 4 Donetion 5 Other (Specify)	Metro Crema			5/00	Balt	imore,	MD		
and a	21. Signature of Funeral Service Licensee									
E 5 8	21. Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228									
Medical kaminer	Immediate Ceuse (Finel disease or condition resulting in death) DILATED CARDIOMYOPATHY WITH FOCAL MYOCARDITIS a. Due to (or es e consequence of):									
shysician and the burial-transit dical Examir	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events Due to (or es e consequence of):									
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pleted						an autopsy med?	24b. Were au available completi of death	prior to on of cause		
Page 2					1027	'es 2□No	1/2 Yes	2 No		
ector Be	25. Was case referred to medical examiner?		Lou	26. Place of Dee	th (Check only o	ne)				
00	1 ☐ Yes 2 ☐ No Hospitel: 1 ☐ Inpatient	2 ER/Outpatient 3								
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To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	2 Accident investigation 3 Suicide 6 Could not be determined 6 Homicide 6 City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)							e Number,		
within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner end manner steled.							ause(s)		
To the comple	29b. Signature end fittle of certifier		29c. License				d (Month, Day, 1			
	30. Name and address of person who completed ceuse of deeth	(Item 23a) (Type, Print)	OCME		rmot B		12, 2000			
State	Stephen S. Radentz 31. Date filed (Month-Day Year) 32. Registrers S	igneture	111	l Penn St	reet, B	at chiloti	e, Maly	Lanu Z1Z		
State Registrar	MAR 1 5 2000 LEGISLAND	3 19 1	200 6							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month Year MARY MAGNESS 3,2000 March 9:00AM 4b. City. Town, or Location of Death 4e Facility Nama (If not institution, giva street and number) 4c. County of Death Rosedale Baltimore Franklin Square Hospital Center If Under 1 Year If Under 24 Hrs. 7. Aga (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) Months 215-16-9209 1 □ M 2 1 F 78 Yrs. Sept. 27 1921 Maryland Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD HArford Abingdon 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 3202 Meadow Valley Drive USA 12. Was Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11. Marital Status 1 Nevar Married 2 Merried 1 Yes 2 No If Yas, Giva Yaar or Datas: Specify: White 1 ☐ Yes 2 ☐ No Specify: 3℃XWidowed 4 □ Divorced 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Etamantary/Secondary (0-12) College (1-4or 5+) Homemaker own home 8th 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surname) John M. Rosenberger Anna Lvell 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3202 Meadow Valley Drive Marlette Hess / daughter Abingdon Md 21009 20b. Place of Disposition (Nama of cematary, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 3/16/2000 Metro Crematory Inc. Baltimore Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Address of Facility
Connelly Funeral Home of Essex 21. Signatura of Funaral Sarvice Licensee 300 Mace AVe. Baltimore Md. 21221 as that caused the death to not entar tha mode of dying, such as cardiac or respiratory arrest, use on each line. 23a, Part1. Entar tha disaasa, or complici shock, or heart feilure. List only on Approximata Interval Between Onset and Death Immediata Causa (Final Sepsis 10 Days disaasa or condition rasulting in daath) Dua to (or as a consequence of): torated Duodena Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or thjury that initiated evants rasulting to death) Last Dua to (or as a consequence of) Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only one)

and ettending physician for use as the burie Box 68760. P.O. been signed by the Records, 8 certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or llama 23a or 28a-f show the Medical Examinar must be notified at

Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic ev

Physician /Medical

Examiner

Physician/Medical

by

Be

Medical Certification: To

29b. Signatura and titla of certifian

page 2 should Completed

19gness, Mary Baltimore, Maryland 21215-0020

must be notified at

Director

Funeral

by

Completed

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Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was casa rafarred to medical axaminar? Hospital: 1 the Inpatient 2 ER/Outpatient 3 DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Tima of 1 Natural 2 Accidant 5 Panding invastigation 1 ☐ Yes 2 ☐ No 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the best of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifian

29c. License number

98861

Drive Baltimore, MD 21235

29d. Data signed (Month, Day, Year)

March 13, 2000

State

Registrar

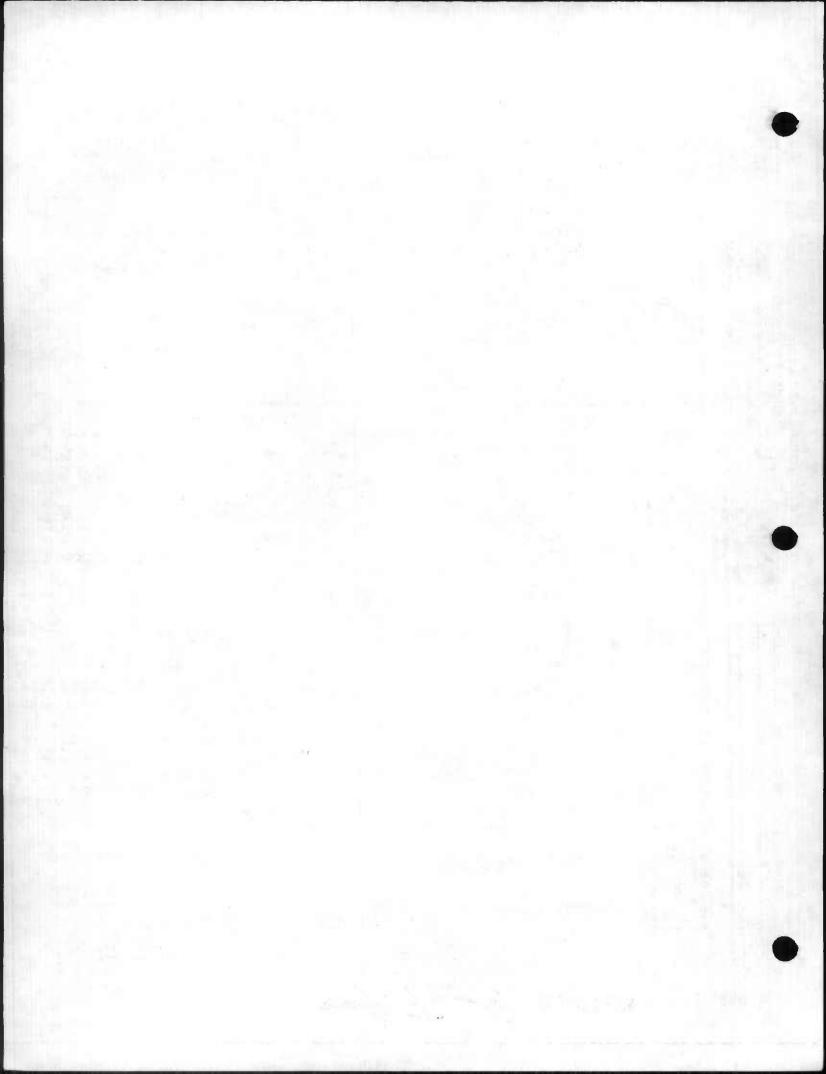
To the Funeral Dir.
To the Funeral Dir.

MD

9000 Franklin Square

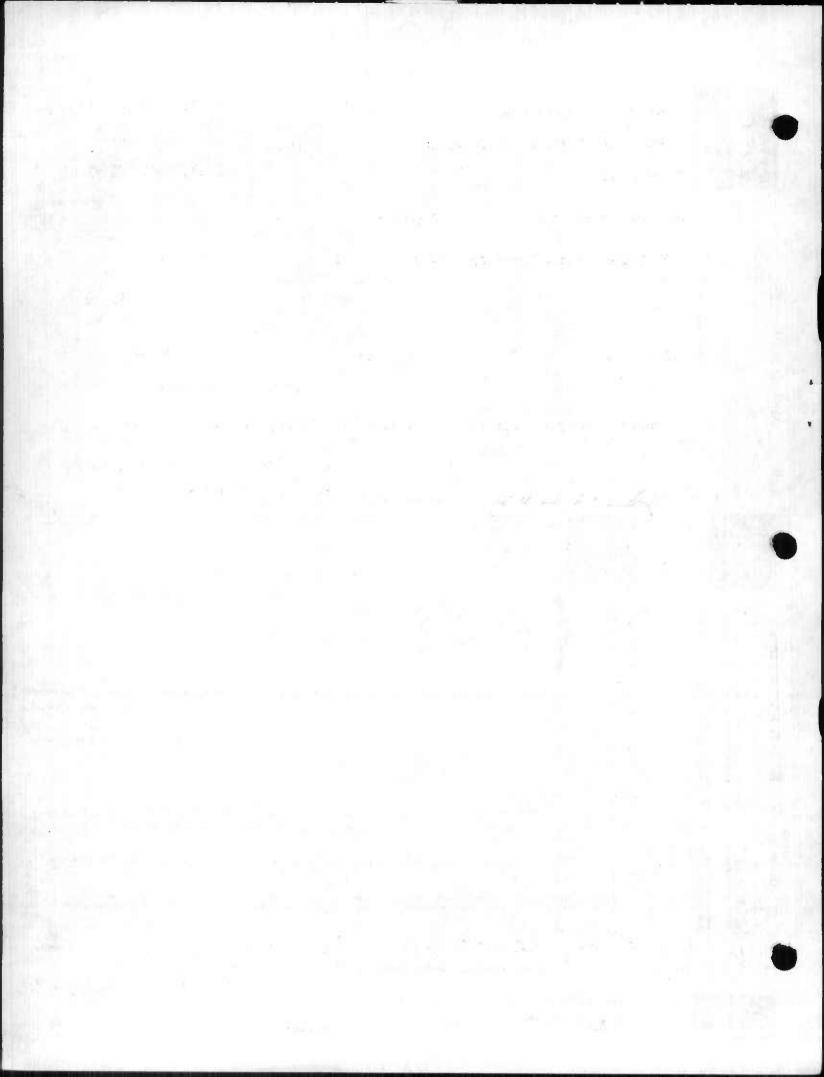
32 Agaistrace Signatura

30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Dacedant's Nama (First, Middla, Last) 2. Data of Death March 13, Day 2000 Yaar **Physician** Arthur Edwin Mormann 6:30 pm /Medical 4e. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Daath Examiner Charlestown Retirement Community Baltimore Catonsville 8. Data of Birth
June 27, 1904 7. Aga (In yrs. last birthday) If Undar 1 Yaar Months Days If Undar 24 Hrs. Hours Min. 5. Social Sacurity Numbar 9. Birthplace (Stata or Foraign **Funeral** Maryland 212-05-0434 Director Usual Residanca of Dacedant the Maryland 10d. Insida City Limits 10a, Stata 10b. County 10c. City, Town or Location ?? is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at Maryland Baltimore 1 Yas 2 No Catonsville Director 10e. Straat and Number 10f. Zip Coda 10g. Citizan of What Country? 707 Maiden Choice Lane; Apt. 8220 21228 United States death 12. Was Decedant Evar in U,S. Armed Forcas? 14. Raca - Amarican Indian, Black, Whita, atc. Was Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 1 ☐ Yas 2 X No If Yas, Giva 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: White 3 □ Widowed 4 □ Divorcad Yaar or Datas: 15. Decedant's Education (Spacify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Businass/Industry other than * entery/Secondary (0-12) College (1-4or 5+) 12th Grade Bell Atlantic Engineer 2+ 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) . Pages 1 end 2 should be fill ment of Health end Mentei H tant: If item 27 is merked out Be Arthur N. Mormann Edith Lavinia Harmon 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Carolyn Manning - Daughter 21 Iron Mill Garth; Hunt Valley, Maryland 21030 other 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval Irom Stata permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Othar (Specify) Woodlawn Cemetery 3/17/2000 Woodlawn, Maryland 21. Signatura of Funaral Sarvica Licansaa 22. Nama and Addrass of Facility Loring Byers Funeral Directors, Inc. M00869 8728 Liberty Road; Randallstown, Maryland 21133 · P7 23a. Park Enfer the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate fntarval Batween Onset and Death **Physician** /Medicai Immediata Causa (Finel diseese or condition rasulting in death) WEEK NEUMONIA **Examiner** Due to (or as e consequança of): Examiner g physician end es the buriel-transit certificate be executed Sequantially list conditions, if any, leading to immediata cause. Enter Underlying Causa (Disaasa or injury Dua to (or as a consaguança ol) Name: Division of Vital Records, P.O. Box 88760, Physician/Medical that initiated evants Dua to (or as a consequence of): rasulting in daath) Last signed by the attending d be deteched for use es Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown HENEA by should ! 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deen page 2 s hes 1 Yas 2. No 1 ☐ Yas 2 ☐ No certificate Attending Physician: 25. Wes casa rafarred to medical axeminar? director Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatlant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 PNursing Homa 5 ☐ Rasidanca 8 ☐ Othar (Specify) 1 Yas 2 No 2 After this funeral 27. Mannar of Death 28a. Data of fnjury (Month, Day Year) 28b. Tima of 28d. Dascribe how injury occurred 28c. fnjury at Work? Certification: 5 Panding invastigation Natural death. 1 Yas 2 No i or Attendi after death Director: A d in by the fi 2 Accident 6 Could not be datarmined 3 ☐ Suicida 28f, Location (Straat and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, streat, factory, office building, atc. (Specify) filled in by 4 T Homicida To the Hospital o within 24 hours af To the Funeral Di completely filled in 29a. Cartifier 12 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and menner as steted. edical 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signatura and tilla of certifiar 17.0 30. Nema and addrass of person who complated causa of death (Itam 23a) (Type, Print) 711 MAIDEN CHOICE LANE CATONIVILLE, MO 21228 NARRETT 32. Registrar's Signature Registrar

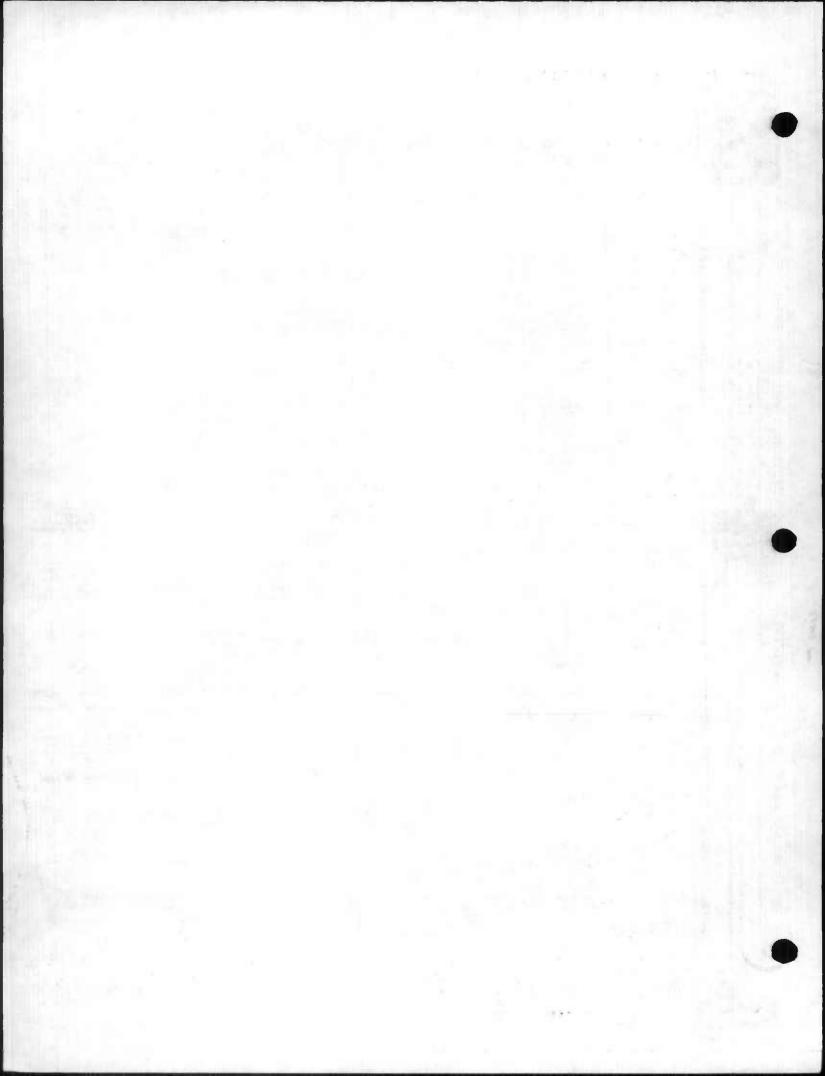


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	3apt2, #26 perPHYG781 :	State of Maryland		te of Death	2. Date of Di	Reg. No.	0 08639				
ysician Medical	Eachity Name (If not institution, give s	treetand number)	7	MANN 4b. City, Town/or	Month FEBRUA	14 04 2	Year 3. Time of Death 1. 15An of Death				
neral 5. S	Social Security Number 6. Sex	BOYUEKW ME 7. Age (In yrs. II M 201 F 91	ast birthday) If Under Yrs. Months	EL BALT or 1 Year IT Under 24 Hrs	MORK B. Date of Bi	rth ay, Year)	N/A 9. Birthplace (State or Foreign Country) MD				
40	a. State 10b. County		, Town or Location		1,100		10d. Inside City Limit				
Funeral Director	MD	/A	Baltin	ore			1∏ Yes 2□N				
Directo	e. Street and Number		10f. Z	p Code		10g. Citizen of W					
Funeral 11.	3319 Meuller Stre	et 2. Was Decedent Ever in U.S	S 13 Was Dec	21224	Specify Yes or No	US 14. Race	A - American Indian,				
p	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Yeer or Dates:	If Yes, sp	odent of Hispanic Origin? (\$ ecify Cuban, Mexican, Puer 2∏ No Specify:	to Rican, etc.)	Specify:	White, etc.				
E .	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) unknown	completed) College (1-4or 5+) Unknown	16a. Decedent's Use (Give kind of w life. DO NOT	ork doné during most of wo use retired)	rking	16b. Kind of But	nknown				
o Be	Father's Name (First, Middle, Last)			18. Mother's Na	Wite:	, Maiden Sumame					
19	unknown a. Informant's Name/Relationship (Typ			s (Street and Number of H			State, Zip Code)				
	J. Hopkins Bayviev a. Method of Disposition 1 Burial 2 Cremation 3 Rev 4 Donation 5 Other (Specify)	20b. Pla	4600 Eas ace of Disposition (Nametery, crematory or		Altimore Date		224 City or Town, State				
21	21. Signature of Juneral Service Licensee Ronald S. Wade, Director 22. Name and Address of Fecility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201										
dis	shock, or heart feilure. List only on imediate Cause (Finel sease or condition sulting in death)	PNEU	MONTA es a consequence of	:			tritervel Between Onset and Death				
Ca Ca Ca tha	bequentially list conditions, any, leading to immediate use. Enter Underlying ause (Disease or Injury at Initiated events sulting in death) Last		as a consequence of								
by Physician/Me	L d										
Na Per	rt II. Other aignificant conditions cont		Nid tobacco use contribute to the cause of deat								
	HIP PACH	10	Yes ZILINO	/es 2 No 3 Probably 4 Unkno							
Completed						s an autopsy ormed?	24b. Were autopsy finding available prior to completion of cause of death?				
						Yes 20 No	1 ☐ Yes 2 ☐ No				
To B	Was case referred to medical examiner? I Yes 2 No Hi Manner of Deeth Abutural 5 Pending investigation	7	one) idence 6 Othe how injury occurre								
Certification:	3 Suicide 6 Could not be determined	28f. Location City or To	(Street and Number wn, State)	or or Rural Route Number,							
	a. Certifier (Check only one) Certifying Physical Examin	clan: To the best of my know er: On the besis of examinati and manner stated.	riedge, death occurred on and/or investigation	at the time, date and place, in my opinion, deeth occ	e, and due to the urred at the time,	cause(s) and mar , date and place, a	nner as stated. nd due to the cause(s)				
-	b. Signature and street, certifier	un	21	97015		29d. Date signed	(Month, Day, Year)				
30.	Name and abdress of person who cor athryn J. Eubo	npleted cause of death (Item	23a) (Type, Print)	BAYVIKWM	Desce	ter Boll	MAZULAND				
State 31.	Date filed (Month, Day, Year) MAD 1 5 2000	32 Registrar's Signatu	yre G. So	ake							

DHMH 16 Rev 6/95

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Please Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year 6:55 Pm MARCH 13 2000 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth SINAI HOSPITAL OF BALTIMORE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Hours Min. Month, Day, 5. Social Security Number 6. Sax 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foreign 9260 1□M 2ØF Months 215-16-9260 Usuel Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location 1 Yas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Wes Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. 14. Race - American Indian, 11 Meritel Stetus Bleck, White, etc. 1 Never Merried 2 Married 1□ Yes 2D(No Specify: Specify: 3 Widowed 4 □ Divorced Yeer or Dates: 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementary/Secondery (0-12) College, (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) 19e. Informent's Neme/Reletionship (Type, Print) Meiling Address (Street and Number or Rural Royte Number, Stete, Zip Code) 20e. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ Removel from Stete 20b. Plece of Disposition (Name of cametery, cremetory or other) Date 20c. Location - City or Town, Steta Mem. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama end Address of Fecility 21. Signafore of Funeral Service/Licensee 20 Home Md. 2121 discusse, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, failury. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Finel . HYPOTHERMIA disease or condition resulting in deeth) Due to (or as a consequence of): HYPOGLYCEMIA Due to (or es a consequence of): Due to (or es e consequence of)

Physician /Medical Examiner

signed by the

this

A hours after dear. within 24 hours after des To the Funeral Director completely filled in by th

Hospital

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Be Completed

Medical Certification: To

important: If Item 27 is: any injury or other

Physician

/Medical

Examiner

Funeral

Director

show

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KULA B. MOODY

Maryland

Baltimore,

Box 68760

P.O. |

Records,

Division of Vital or Attending Physician:

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and Mental

must be notified

Director

Funeral

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Examiner Sequantially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Physician/Medical by

Pert II. Other algnificant conditions of	ontributing to death but not re-	sulting in the unde	erlying ca	ause given in Pert I.	1 Yea 2 P No	3 Probably 4 Unknow		
			H		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?		
25. Was case referred to medical			-	26. Place of D	eath (Check only one)			
exeminer? 1 Yes 2 No	Hospitel: 1 Inpatient 2	ER/Outpatient	3 DO	A Other: 4 Nursing	Home 5 ☐ Residence 6 ☐Ott	her (Specify)		
2 LI ACCIDENT	aturel 5 ☐ Pending (Month, Dey Year) Accident investigation		M 2	8c. Injury el Work? 1 Tyes 2 No	28d. Describe how injury occurred			
3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At h building, etc. (Speci		, fectory	, office	28f. Location (Street end Num. City or Town, Stete)	ber or Rural Route Number,		

City or Town, State)

29e. Certifier (Check only one)

1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end menner stated.

29b. Signatura and title of certifier

29c. License number

BELVEDERE

29d. Date signed (Month, Day, Year)

C. EARL GRANT, M.D.

QRANT

WEST

AS2402321

MARCH 13 2000

AVENUE, BALTIMORE, MD 21215

30. Nema end address of person who completed cause of deeth (Item 23a) (Type, Print)

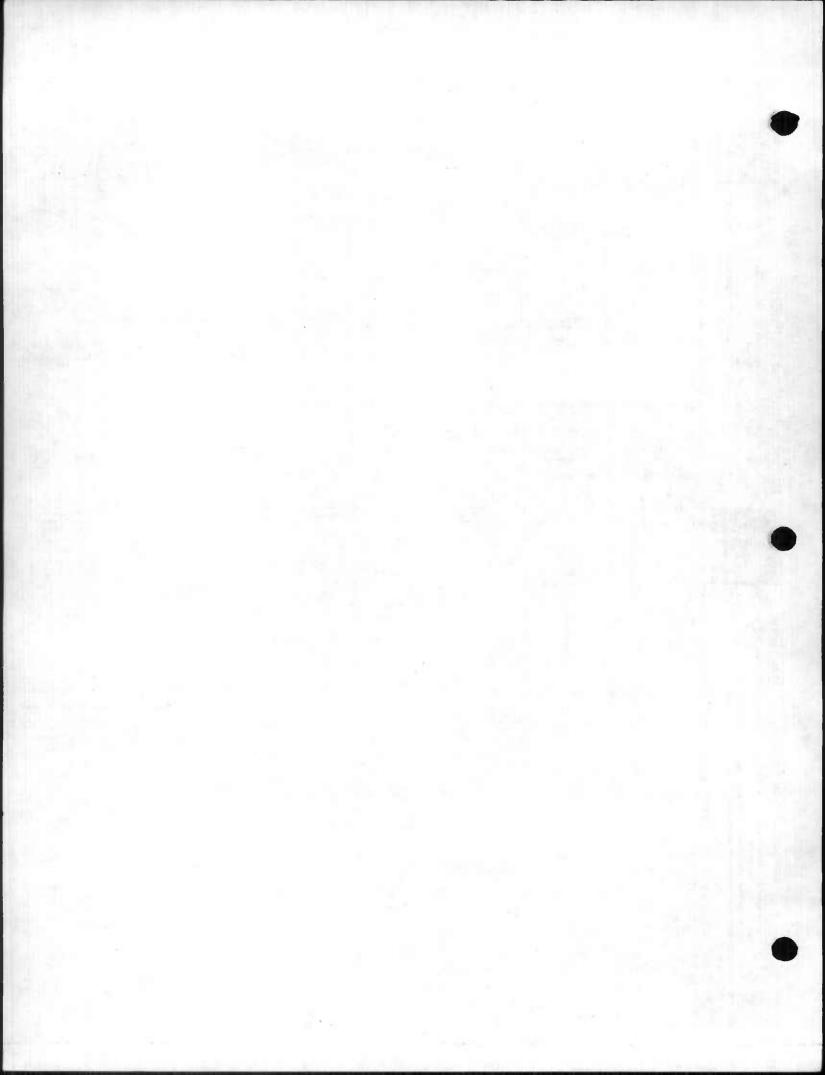
M.D

G. EABL State Registrar

31. Data filed (Month, Dey, Year)
MAR 1 5 2000

32. Registrer's Signature

2401



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Year KEGINA MARTIN 23:40 00 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHINS HOPKINS MES CNTR SAYVITER BALTIMORE | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Sept. 1,1917 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 2 F Days 215-03-8435 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 21XNo Dundalk Baltimore Maryland 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 21222 United States 3309 McShane Way 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 7 Years Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Mary Helen Shover Emil William Wienecke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2607 Liberty Parkway Dundalk, Maryland 21222 (Granddaughter) Ms. Lisa Rao 20b. Place of Disposition (Name of 20a. Method of Disposition Dete 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State Dulaney Valley Mem. Gdns. 3/15/00 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 1. Dias 7922 Wise Ave. Dundalk, Maryland 23a. Partf. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 12-24 disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner The law requires that the death certificate be executed Box 68760. P.O. Records, Division of Vital

94 28 98n signed by the atte certificate Attending Physician: funeral director, After this To the Hospital or Attendir within 24 hours after death. To the Funerel Director: Al filled in by completely

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or frams 23a or 28a-f ahow The Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Rem 27 is marked other than "natural", or field any Injury or other traumatic event

Physician /Medical

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

Be

Physician/Medical Examiner

Be Completed by

Certification: To

Medical

Registrar DHMH 16 Ray 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CSASA State

29a. Certifier

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) WAR 1 5 2000

KOVESAY 41 37 Registrar's Signature

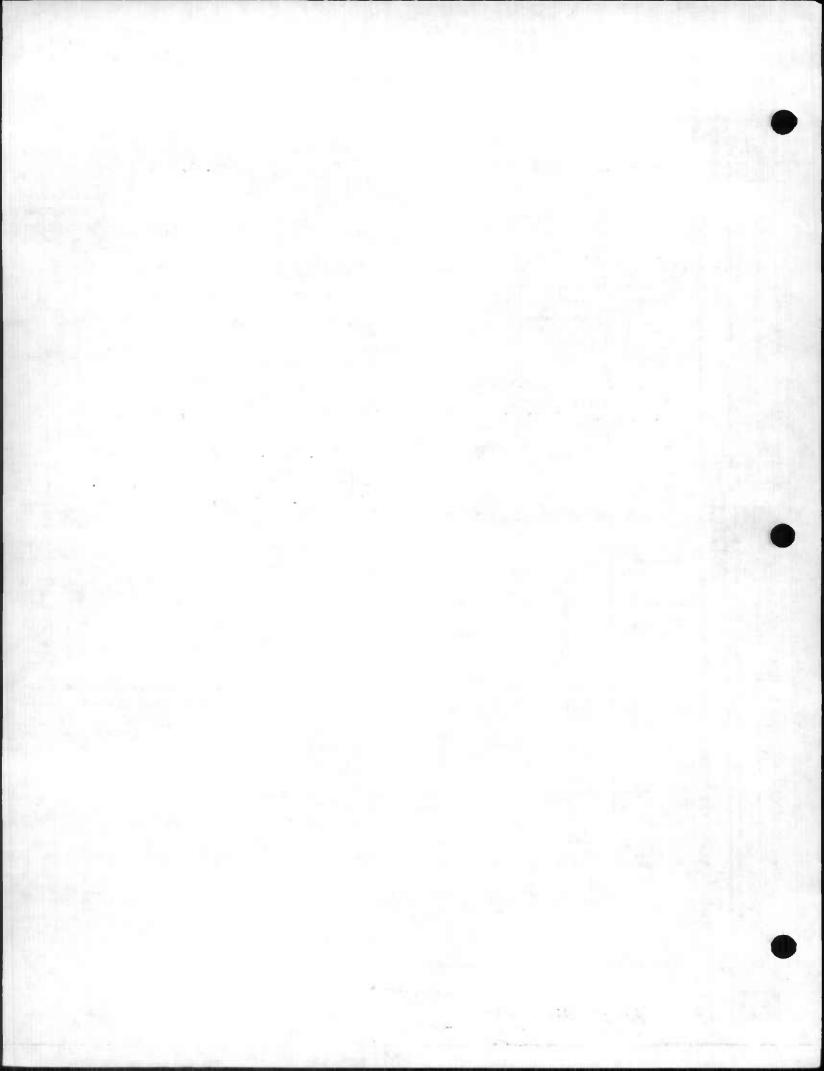
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

52N

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Time of Death March 13° 2000 2000 **Physician** 8:03PM McVev Charles Arthur /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Joseph Medical Center Baltimore Towson If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Feb. 15 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1928 Maryland 1₩ M 2□ F 72 217-24-4534 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Baltimore Lutherville 1 ☐ Yas 2 ☐ No Director 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 21093 USA 613 Morris Ave. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indien, Bleck, White, etc. 11 Maritel Stetus ty Yas 2 No If Yes, Give Year or Detes: 1 Nevar Merriad 2 Married WWII Specify: White 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) +4 Lab Research Technician Ceramics& Coatings attimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be next of Health and Mental Aurora Rose White Louis John McVey 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Dorothy McVey/Wife 613 Morris Ave. Lutherville, Md. 21093 20b. Place of Disposition (Name of cometery, crametory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 DxBuriel 2 Cramation 3 Removel from State Dulaney Valley Mem. 3 - 17 - 00Timonium, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc 21. Signature of Funeral Segrice Licenses 1050 York Rd. Towson, Md. 23a, Part1, Enfor the disease, or heart failure. List that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, a cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disease or condition resulting in deeth) Examiner Examiner 2 Daeu Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. þ & Blodder Ca 1/97 24b. Were autopsy lindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical exeminer?

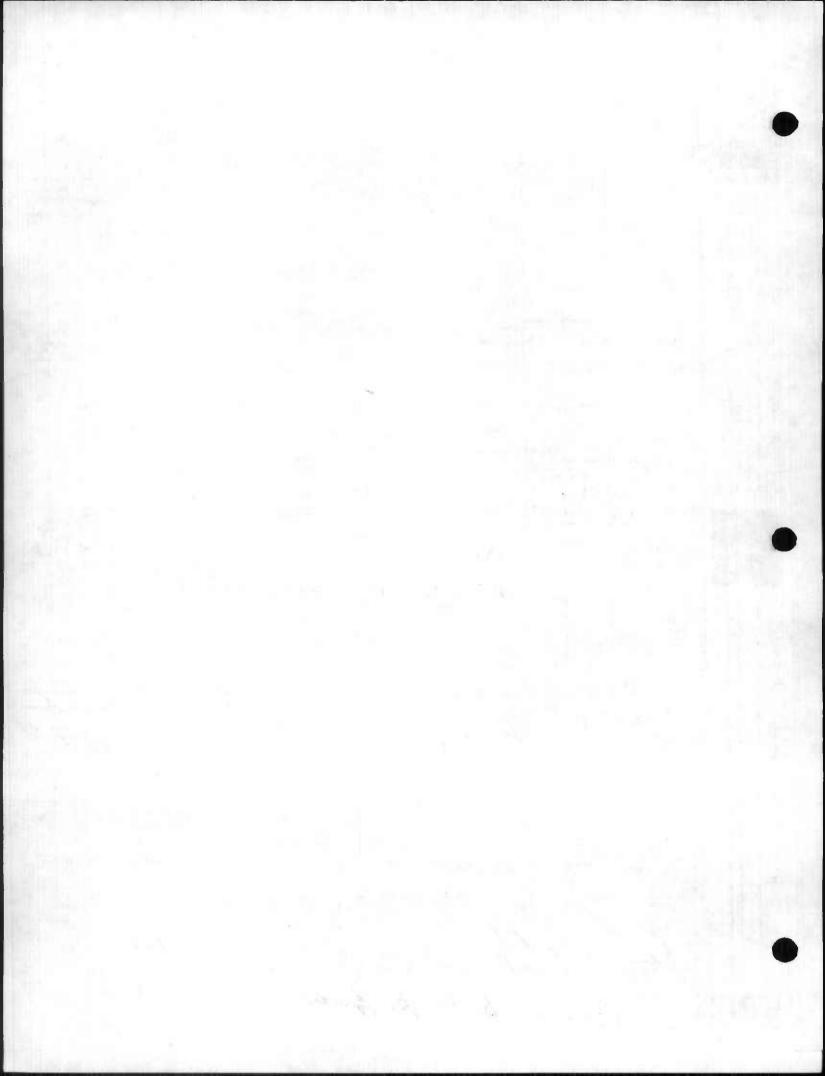
1 Yes 2 No 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 1 Naturel 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After 1 Yes 2 No investigetion 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, lerm, street, lectory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) end menner as stated.

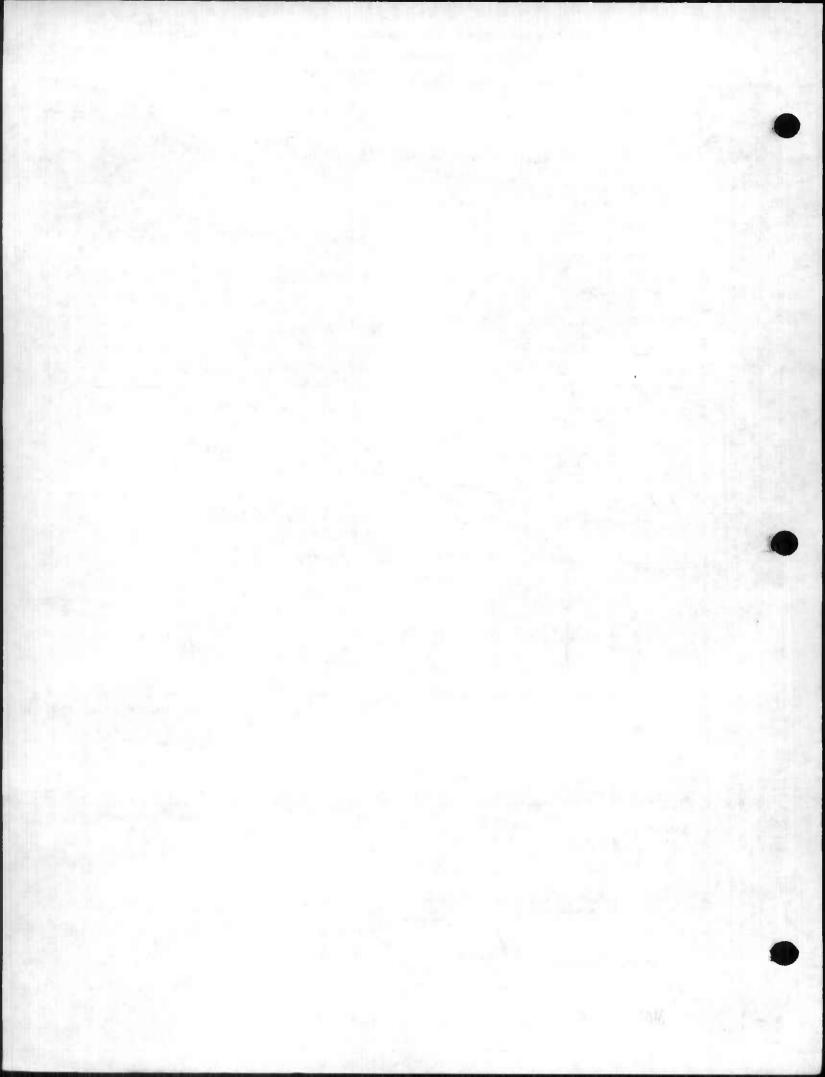
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner, steted. 29e, Certifier 29b. Signature and 199 of certifier 29c. License number 29d. Date signed (Month, Day, Year) 007132 30. Name end address of person who completed/cause of death (Item 23a) (Type, Print) 5.15 FAIRMOUNT AVE TOWSON, MD. 21204 FEZZOCI, M.D RICHARD MAF 32. Registrar's Signature 31. Date filed (Month, Day, Year) MAR 1 5 2000 Registrar

DHMH 16 Rsv 6/95

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hysician i	1. Decedent's Name (First, Middle	e, Last)		ertificate	07.	Doutif	2. Date of D	Reg. No.	Year	3. Time of Death		
/Medical	JOSEPHDI	NEEDLE	MAN			4) (i) T	3	11 2	000,	12.30Pm		
xaminer	4a Facility Name (If not institution LEVINDALE	i, give street and numb	9r)		1	4b. City, Town, or BALTIMOR		th 4c. Count	y of Delith			
at E	5. Social Security Number		Age (In yrs. last birthda	y) If Under 1 Months	Year	If Under 24 Hrs Hours Min.	8. Date of Bi	rth av. Year)	9. Birthp	lace (State or Foreign		
	219-12-5072 Usual Residence of Decedent	10 M 20 F	76 Yrs.				DEC 24	11923	MD.			
	10a. State 10b. County	F. The Trib.	10c. City, Town or	Location	. //				t	Od. Inside City Limits		
Director	MD N/A		BALTIMORE							1 Yes 2 No		
ı	10e. Street and Number 4222 LABYRINTH		10f. Zip (212	215		10g. Citizen of	USA				
11. Marital Status 12. Was Decedent Armed Forces				3. Was Decede	nt of H	lispanic Origin? (Sen, Mexican, Puer	pecify Yes or N		ce · Americ	en Indian,		
	1 Never Married XMarr 3 Widowed 4 Divorced	No WW II	1 Yes 2		Specify:	Specify:WHITE						
and Hypene of other than "natural", o event, the Medical Exa Be Completed by	15. Deceden (Specify only highes		(Gi	cedent's Usual ve kind of work	done	during most of wo	rking	16b. Kind of E	Business/Inc	dustry		
	Elementary/Secondary (0-12)	life	INEMAN	retired	d)		AMERICA	N NAT	IONAL CAN			
	17. Father's Name (First, Middle,			18. Mother's Name (First, Middle, Ma								
	WILLIAM	VEEDLEMAN						iplan (UNKNOWN)				
	t9a. Informent's Name/Relations ROSE NEEDLEMAN/						er, City or Town, State, Zip Code) , MD. 21215					
	20a. Method of Disposition ✓ Burial 2 □ Cremation	2 □Pomoval from Sta	20b. Placa of Dis	position (Name rematory or off	of er plac	ce)	MAR. 14	20c. Location	- City or To	own, State		
I	4 Donation 5 Other (S	pecify)	ARLINGTO	N-CHIZI			2000	BALTIMO	RE, M	D.		
Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury	b	Due to (or as a cons	sequenca of):		ANC	ER_		1 0 1 4 2 3 3			
Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death of the cause of death o										Hall I		
	Part II. Other significant condition	ut not resulting in the underlying cause given in Part I.					23b. Did tobacco use contribute to the cause of death					
				24e. We				av	ere autopsy tindings ailable prior to impletion of cause death?			
								Yes 2 No		Yas 20 No		
							1 1	162 561140	ath (Check only one)			
2	25. Was case referred to medical examiner?				Tour							
000	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 Inp		of 28		ner: Nursing I	ath (Check only					
000	examiner? 1 Yes 2 No	Hospital: 1 Inp 28a. Date of I (Month,		of 28	c. Injur Wor	ner: Nursing I	ath (Check only Home 5 Res 28d. Describe	one) sidence 6 Dot s how injury occu	rred			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **OMANSKY** LOUIS MARCH 12 2000 08:29 4a. Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death ST. AGNES HOSPITAL BALTIMORE N/A H Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 7/13/1907 5. Social Security Number 7. Age (In yrs. lest birthday) 9. Birthplace (State or Foreign XIX M 2 F 92 Yrs. NEW YORK 212-03-9837 10e. State 10b. County BALTIMORE CATONSVILLE 10d. Inside City Limits 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21228 USA 815 WINTERS LANE APT. 211 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, GiveX Yeer or Dates: 1 ☐ Never Married 2 ☑ Married 1 Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) WESTINGHOUSE AIR PRECISION MACHINIST DIVISION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) HELEN SMITH **OMANSKY** ISAAC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) HEDY B.OMANSKY/WIFE 815 WINTERS LANE APT. 211 CATONSVILLE, MD. 21228 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) BALTIMORE HEBREW 3/14/2000 REISTERSTOWN, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS. INC 21208 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset end Death Immediate Cause (Finat disease or condition resulting in death) · I Cexpiratory 1 how Preumonica lween Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably ₩ Unknown Heart Failer, employeena 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? artery disease diabeter 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ENOutpetient 3 ☐ DOA 1 Yes 2 No 28c. Injury at Work? 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

Examiner buriel-transit and physician a the buriel Box 68760. P.O. Records, After this certificate of Vital Division

Physician

/Medicai

Examiner

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by

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7 is marked other than "natural", or items 23a or 28a-f ahor traumatic event, the Medical Examinat must be notified at

permit. Peges 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than any injury or other traumetic event, the Me

Physician /Medicai

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Medical Certification:

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signed by t To the Hospital or Attending Pt within 24 hours efter death.

To the Funeral Director: After th completely filled in by the funeral

State Registrar

DHMH 16 Rev 6/95

31. Dete filed (Month, Dey, Year)

29a. Certifier (Check only one)

Eldser Greenwall

1365848998

29c. License number

Testifying Physician: To the best of my knowledge, death occurred at the time, date and piaca, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piaca, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) March 12, Zous

30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

MID

mo Stagnes Hospital Balhnon, me 21729

29b. Signature end title of certifles

32. Registrar's Signature

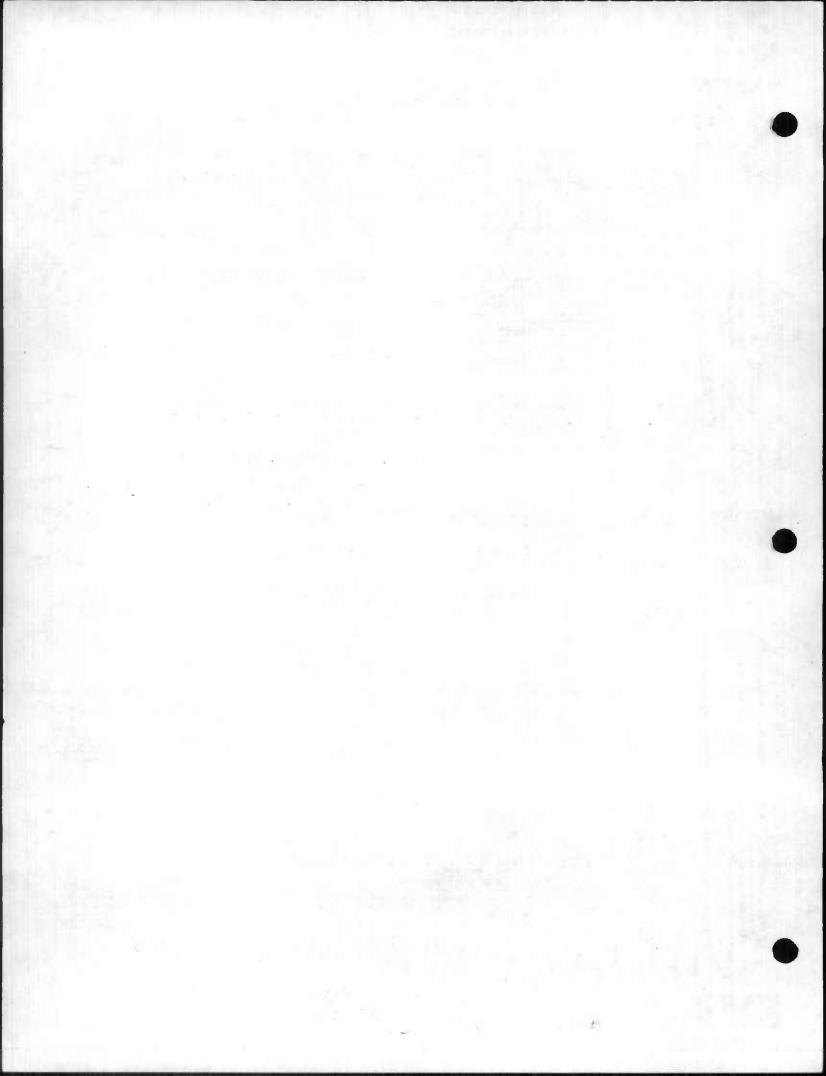
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State of Maryland / Department of Health and Mental Hygiene

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Examiner	4a Fscility Name (If not institution, give	street and number)				4b. City, Town, or Li	ocation of Death			
Funeral Director	GREATER BALTII 5. Social Security Number 6. Se 216-18-9462 11		ICAL CEN e (In yrs. last birthda Yrs.		1 Year Days	TOWSON If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h y. Year)		ce (State or Foreign
Director	Usual Residence of Decedent		11				March	4,1923	[Mary]	land
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death death selfor u	Part II. Other significant conditions co	ntributing to death b	ut not resulting In the	underlying c	Ausa di	ven in Part I	23b Did I	lohacco use co	ontribute to ti	he causs of death?
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37	30. Name and address of person who or		eath (Item 23a) (Typ		N. C	harles St	. Balt	imore,	MD	
State : Registrar	31. Date tiled (Month, Day, Year)		ar Signature	B.	Si	ach	-, Dare	2111026	- 22	

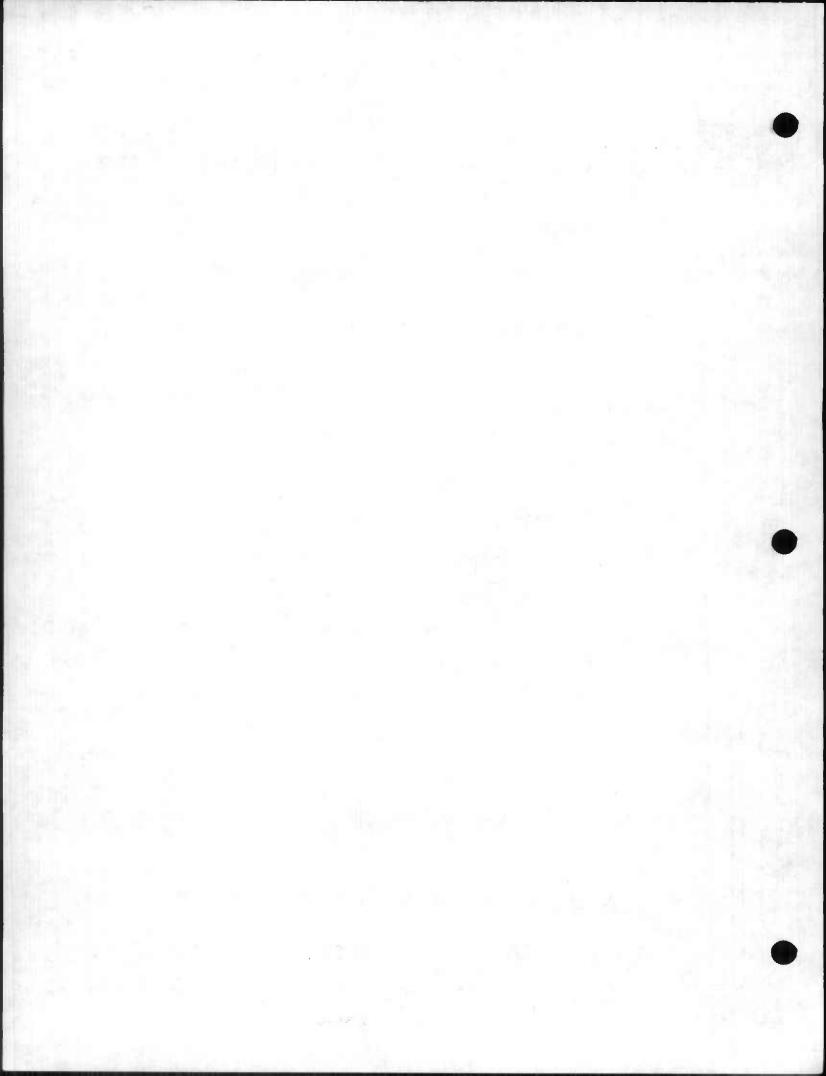


State of Maryland / Department of Health and Mental Hygiene 00 08646

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DHMH 16 Rev 6/95

Registrar



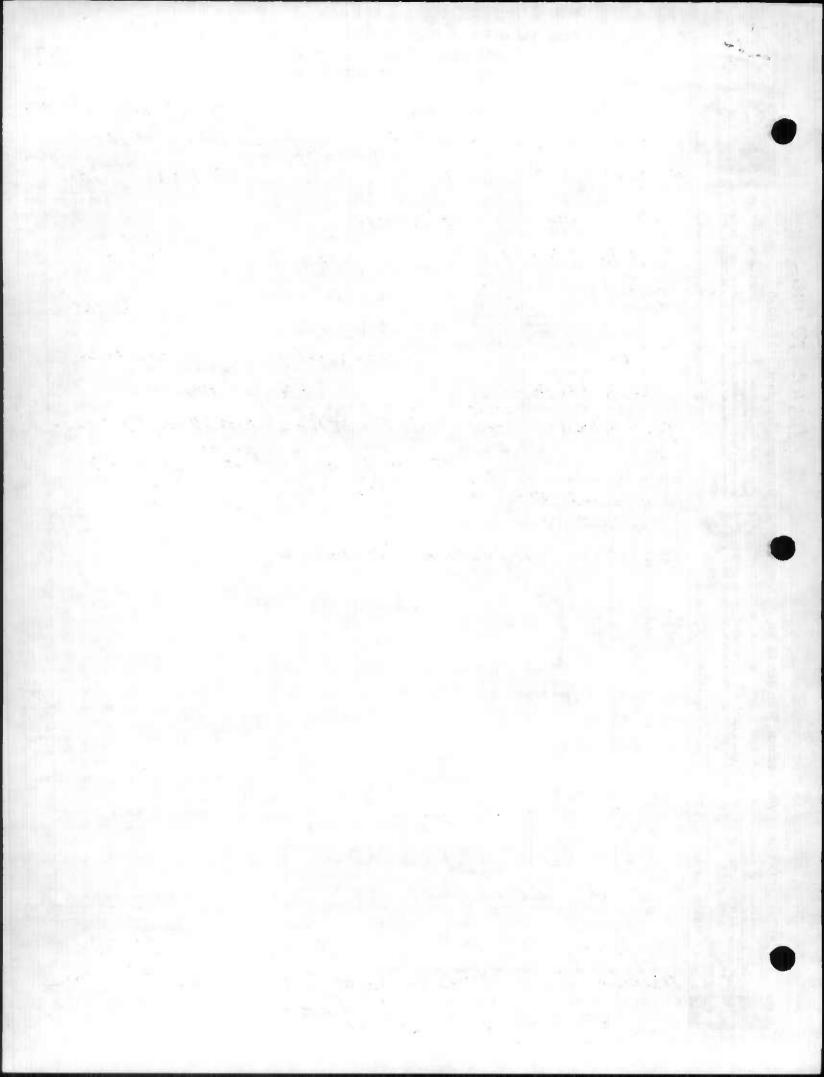
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First Middle Last) 3. Time of Death 9, 2000 1230 **Physician** MRCh TER /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street end number) Examiner General paryland 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) Months Days 231-22-9023 Hours 1 M 2 F Yrs. **Director** Usual Residenca of Dacadant the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2□No Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23e or other traumatic event, the Modical Examiner must be a AVE. U. 5.A 2095 Funeral 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yas, Give Year or Dates: 14. Race - Amarican Indian, heter talmer Black, Whita, etc. Peges 1 end 2 should be filed within 72 hours after nent of Health end Mental Hygiena. 1 Navar Married 2 Married 8 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 Widowed 4 □ Divorcad Completed 16a. Decadant's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collage (1-4or 5+) 12 STEEL WORKER 18. Mothar's Nama (First, Middle, Meiden Sumeme) 17. Fathar's Nama (First, Middle, Last) Be PALMER -ANNIE UNKNOWN 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) DEDI. OFAGING BALTIMORE, MD. 21202 Item 27 SHAW 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetery or other pleca) Date 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Othar (Specify) important: If it eny injury or c CAPMEL CEM. 22. Nama and Addrass of Facility, 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disedee, or complications that caused the death. Do not anter tha mode of dying, such as cardiac or respiratory arreat, shock, or haart failura. List only one cause on each lina. Approximata Intarval Between Onset and Death Physician Immediata Causa (Final diseasa or condition resulting In death) /Medical Examiner Due to (or as a consequance of): Examiner physicien and the burial-transit Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): the death certificate be axec Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequenca of): ettending ph signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? should b 24a. Was an autopsy performad? Completed cartificate has b 1 Yas 2 1 No 1 ☐ Yes 2 ☐ No Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Placa of Death (Check only one) Hospitel: Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 0 1 12 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of Injury (Month, Day Year) 27. Manper of Death 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? Certification: 5 Pending Investigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident efter death Director: 6 Could not be datarmined 3 Sulcide 28e. Placa of Injury - At home, farm, street, factory, offica building, atc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 1 Certifying Physician: To the best of my knowledga, death occurred at the time, date and placa, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, data and placa, and due to the cause(s) and mannar stated. 29a. Cartifier Medical (Check only one) To the Fu 8 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifian 29c. License number 0 muryland General Hospital 30. Name and address of person, who completed cause of death (Item 23a) (Type, Print) Vale m.1.40 Manisha 31. Date filed (Month, Day, Yaar) 32. Registrar's Signature

Registrar

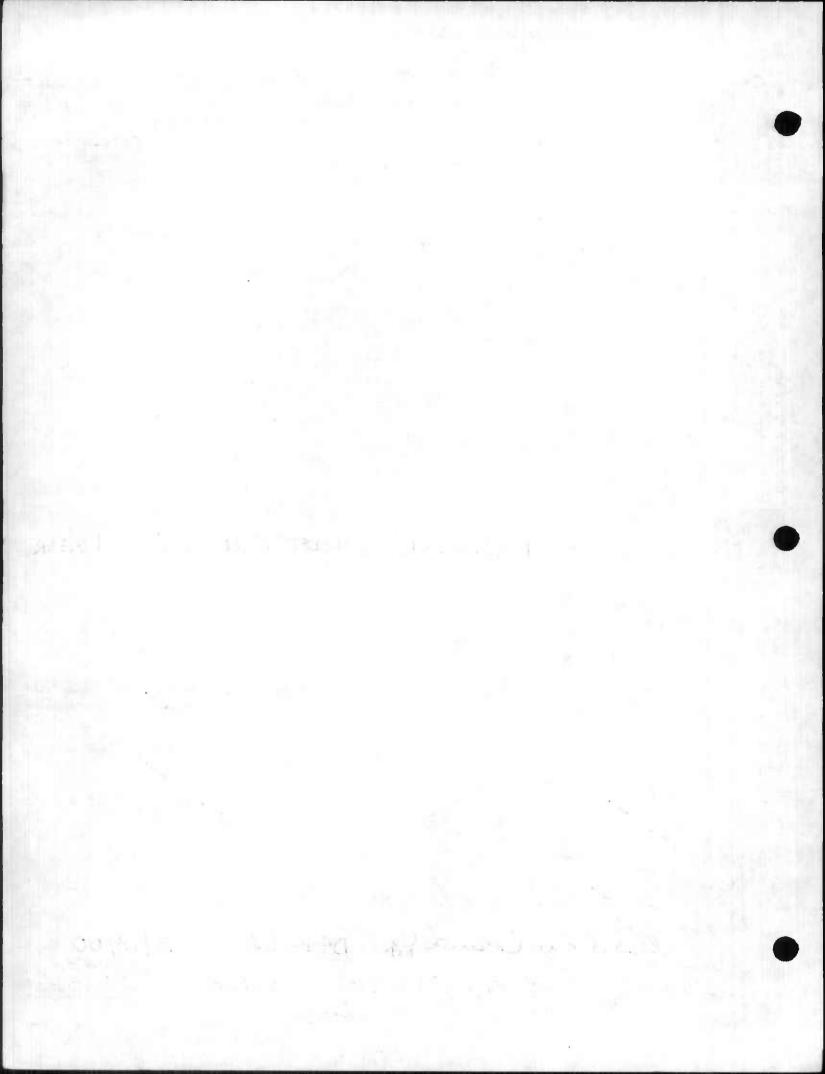
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State of Maryland / Department of Health and Mental Hygiene

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			Cer	tificate of	Death		Reg. No.		00030
Physician	1. Decedent's Neme (First, Middle, L		л так	ID DAIZ	ACKT	2. Date of De Month		Year 0000	3. Time of Deeth 3:45an
/Medical		PATRICIA	A JAN		ASKI	MARCH			3:43all
Examiner	4a Fecility Name (If not institution, g				4b. City, Town, or	Location of Deeti			
	1211 Old Ea			W. 1. 4.V.	Esse	-			imore
Funeral		Sex 7. Age (In yrs.	110 00 00 100 100	Months Deys	If Under 24 Hrs Hours Min.	(Month, De	y, Year)	9. Birthp	lace (State or Foreign try)
Director	217–50–7408	51	l Yrs.			June 2	5 1948	Mar	yland
	Usual Residence of Decedent 10a. State 10b. County	10e Cit	ty, Town or Loc	cation				1	0d. Inside City Limits
Here 23e or 28e-f sho ner must be notified at uneral Director		imore	.,, , , , , , , , , , , , , , , , , , ,		Essex				1 ☐ Yes 2 ☐ No
or 28s4 s be notified Director		22.3					40- 00	10-1 C-11	
D Be	10a. Street and Number			10f. Zip Code	1.001		10g. Citizen of V		iry ?
123 In	1211 Old Eas				21221			SA	and to do a
c hams 2 ploer my Funer	11. Meritel Stetus	12. Wes Decedent Ever in U Armed Forces?	,S. 13. V	Yes Decedent of F Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer	to Rican, etc.)	Blac	e - Americ k, White,	
by F	1 Never Merried 200 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates:	1	Yes 2√ No	Specify:		Specify	· W	Mite
ygiene. ser than "naturn rt, the Medical Completed	15. Decedent's E (Specify only highest g		16a. Deced	lent's Usual Occup kind of work done	pation during most of wo	rking	16b. Kind of Bu	siness/Inc	dustry
SAS E	Elementary/Secondary (0-12)	College (1-4or 5+)					THE CO.		Lion
	12th	.41	Purch	asing Ma	-	me (First, Middle	LUI Co	_	tion
ever Be	17. Father's Name (First, Middle, Las							16)	
Manha milic To		acek				arie Ker			
D E E	19a. Informent's Name/Reletionship			-	and Number or R				
Dec 1	John M. Paskask				stern Av				
T and to	20a. Method of Disposition 1 ☐ Buriel 2 ☑ Cremetion 3		cemetery, crem	sition (Neme of netary or other ple	ice)	Date	20c. Location -	City or 10	wn, State
ment: I	4 □ Donation 5 □ Other (Spec	ify) Me	etro Cr	ematory	Inc. 3/	14/2000	Baltin	more	Md.
y in a	21. Signature of Funerel Service Lice	ensed 0 n/	22	. Name and Addre	ess of Fecility				
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	23a. Pert1. Enter the disease, or co shock, or heert tailure. List or	inplications that caused the don	Do not ente	er the mode of dyi	ng, such as cerdia	Baltimo c or respiratory e	rest,	21221	Approximete
hysician	Shock, or neer tallure. Listory	y one cause on eech line.	7	100	1.5.2.5.			*	Onset and Death
/Medical	Immediate Cause (Final	Metas	table	, bre	ast (can	en	1	YEAR
xaminer	diseese or condition resulting in death)	8.	or as e conseq						
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attending physician and if or use as the bunal-transit clar/Medical Examiner	Securetiathy list conditions	Due to (or es e conseq	neuce of).					
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s the buries	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events	C. Due to (c	or es e consequ	uence off:				-	
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5 5	Pert II. Other eignificant conditione	contributing to death but not res	sulting in the ur	ndenying ceuse gi	ven in Pen I.		_/		the cause of death?
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signed id be de						24a. Was	en eutopsy	24b. W	ere eutopsy findings
been sign should be leted by						perfe	ormed?	co	ailable prior to impletion of cause
2 N D							/	of	death?
S a O						10	Yes 2 No	1[Yes 2 No
s certificate he director, page To Be Com	25. Wes case referred to medical examiner?					ath (Check only	one)		
this certific ral director, To Be	1 ☐ Yes 2 ☑ No		ER/Outpatien	I JU DOA		Home 5 Thes			(y)
h. After th funera funera tion:	27. Menner of Death 1 Naturel 5 Pending	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	28c. tnju Wo	iry at ork?	28d. Describe	how injury occur	red	
octor: After by the fune iffication	2 Accident investigeti	on		M 1	Yes 2□No				
is effer death. In Director: After the in by the funeral Certification:	3 Suicide 6 Could not determine		ome, farm, str	eet, factory, office	11-11-15	28f. Location (Street end Numb wn, Stete)	ber or Rure	el Route Number,
od in by		John W. Co.	.,,						
hour hy fills	29a. Certifier 1 Certifying P	hysician: To the best of my kno	wiedge, death	occurred at the t	ime, dete end plec	e, and due to the	cause(s) and me	enner es s	tated.
within 24 hours To the Funeral completely filled Medical C	(Check only 2 Medical Ext	miner: On the basis of examina and menner steted.	ation and/or inv	vestigation, in my	opinion, death occ	urred at me time,	dete end piece,	and dhe r	o (ne cause(s)
within 24 hours ener deam. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	29b. Signeture end title of certifier	00	00	29c. Licen	se number		29d. Date signe	d (Month,	Dey, Year)
0	Madh	u Can	C KY	P D	4140	6	3	13/	00
10	30. Neme end address of person who	completed ceuse of deeth (Itel	m 23a) (Type.	Print)		1	BALT	7100	DRE,
1	MADUIT (JAI)	DHRVMAG	000 F	RANKI	INDA	ARE DR	mi	21	237
State	31. Date filed (Month Pay Year)	32. Registrar's Sign	eture	11111		- 1	1000	9/	
State Registrar	MAR 1 5	2000 Dener	a b	1. Apr	161				

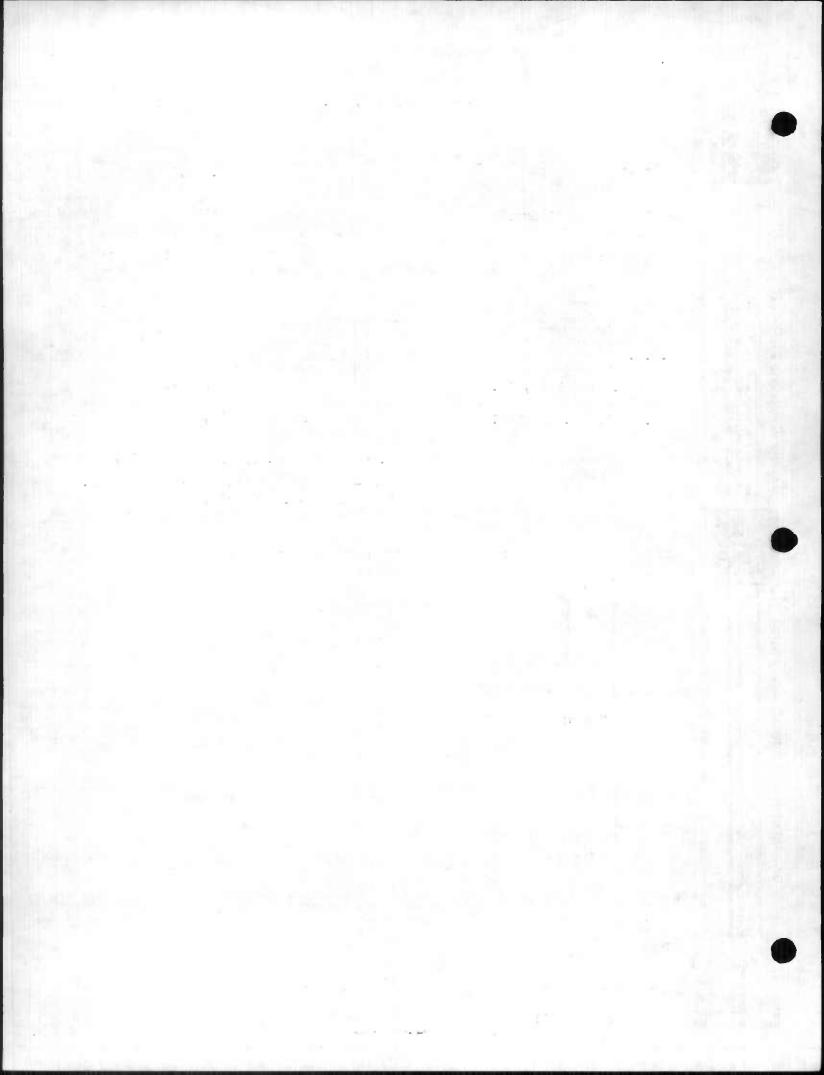


State of Maryland / Department of Health and Mental Hygiene 0 0 8649

					Ce	rtificat	te of	Death			Reg. No.		
	1. Decedent's Neme (First, Mic	idle, Last)								2. Date of De Month	ath	Year	3. Time of Death
Physician /Medical			Jo!	hn Henry	y Prec	htel,	Jr.			March	12, Day	2000	2:54 P.
Examiner	4e Facility Neme (II not institution Johns Hopkins				Center				wn, or Lo	ecation of Deat	h 4c.	County of Dec	
Funeral Director	5. Sociel Security Number 217–20–6689	6. Sex	M 2□ F	7. Age (In yrs. 74	last birthday) Yrs.	If Unde Months	Days		24 Hrs. Min.	8. Date of Bir (Month, Di	th sy, Year) 12,19	9. Bi	rthplace (State or Foreig country) ryland
P .	Usual Residence of Decedent			40.00									T
e Maryta last show tifled at ctor	Maryland 10b. Cour	Balti	Lmore	10c. Cr	y, Town or Le	ocation				Dunda11	<		10d. Inside City Limit
ar death with the Marylar terms 23a or 28e-f show net must be notified at tuneral Director		ah Roa	ad			10f. Zij	Code	212	222			zen of What C .ted St	
Bar, or	3 ☐ Widowed 4 ☐ Divorce	12 erried	. Wes Dec	2 No		Wes Dece If Yes, spe				ecify Yes or No Rican, etc.)		14. Race - Am Black, Whi Specify:	
ed within 72 ha ygiene. wer then "metur it, the Medical.	15. Deced	ent's Educa	tion		16a. Dece	dent's Usu	al Occu	pation during mos	at of work	ina	16b. Kir	nd of Business	Andustry
TO THE PERSON	Elemantary/Secondary (0-12		College (lifa.	DO NOT	se retire	during mos			Ва	ltimor	e Gas &
		- 1			Sup	ervis	or	40.34-16		Contraction			Company
Mental H Mental H sriked of stic ever	John H. Pr	chtel						18. Moth	ers Name	Sophia			
and 2 sho salth and n 27 le me er treum	19e. Informant's Neme/Reletion Mrs. Shelia									ndalk,			Zip Code) 21222
Pages 1 a nent of His ent: If Nern ary or othe	20a. Method of Disposition 1 ☑ Buriel 2 ☐ Cremetio 4 ☐ Donetion 5 ☐ Other		moval from	State	race of Disponentery, cre	matory or	other ple	-	em. 3	Date /16/00		cation - City o	Maryland
Departit Departit Imports any inju	21. Signature of Seneral Servi	e Licensee	£			Duda-	Rucl		eral	Home of			Inc. 21222
	23a. Part1. Enter the disease, shock, or haert feilure. L	or compilea	tions thet	aused the deat	-							Lana	Approximate Interval Between
Examiner in and instransit	diseasa or condition resulting in deeth)	a			or as a conse	quence of)							† † *
deeth certificate be assected eatherding physician and of for use as the burlat-transit siciary Medical Examir		c			r as a consec								1
ing ing		L d.											1
the atte	Pert II. Other significant condi	tions contri	buting to d	eath but not resu	ulting in the u	nderlying i	cause g	iven in Pert	l.	23b. Did	tobacco	use contribut	te to the cause of deati
that the ed by detac	Huperter	sibn	1							10	Yes 2	□ No 3□1	Probably ধ Unknow
											an autop ormed?	sy 24b	Were autopsy findings available prior to completion of cause
has 36 2											ecti Yes 20		of death?
certificate rector, pay	25. Was case referred to medi axaminar?								e of Deat	h (Check only	one)		
hy light I	1 Yes 2□ No	Hos		of Injury oth, Day Year)			UA			me 5 Res			ecify)
Da special	27. Manner of Death 1 X Naturel 5 Pen 2 Accident Inve	28b. Time of Injury	M	28c. Inju Wo 1	ryat ork?]Yes 2□		28d. Describe	how injur	y occurred				
tal or Attanding P rs after death. al Director: After t ed in by the funer Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At homa, farm, street, factory, office 28f. Location (Street and Number of City or Town, State)								Rural Route Number,				
Hospi 4 hou Funer tely fill			r: On the b	best of my knowasis of examinations stelled.									as stated. ue to the cause(s)
within 2 To the comple	29b. Signature and title of certi	ier		1		29	c. Licen	se number			29d. Dat	e signed (Mor	nth, Day, Year)
1.11	1 Catur	to.	en)				O.C.M	.E.		Mar	ch 13,	2000
MI	30. Namy and address of person	n who com	pleted cau	se of death (fterm		-	nn S	treet	, Ba	ltimore	, Ma	ryl.and	21201
State	31. Date filed (Month, Day, Yea	ir)	32. F	Registrer's Signa		7	9	3 ,					
Registrar	MAD 1	5 200	ווווו	Bener	6	7. 6	100	16					

DHMH 16 Rev 6/95

ARR A A PAAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Deta of Death 3. Time of Death Month Year Kodrigues faulo 00 4a. Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth 302 Baltimore Cite Baltimore 6 bone f Under 1 Yeer If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Aga (In yrs. last birthday) 9. Birthpleca (State or Foreign 10M 20 F Months Days Pherto Rico 581- 42-36 Usuel Residence of Decedent 42-361 Yrs. 69 112 10e. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yas 2 ☐ No N/A Baltimore 10e. Sfreet and Number 10f. Zip Coda 10g. Citizen of What Country? 6302 Toone Street 21224 USA 12. Wes Decedent Evar in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yas, Giva Yeer or Detes: 13. Wes Decedent of Hispenic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - Amarican Indien, Bleck, White, etc. 1 Naver Merried 2 ☐ Married Yes 20No Specify: Puerto Specify: 3 ☐ Widowed 4 ☐ Divorced Hispanic Rican 18a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elamantery/Secondery (0-12) Collega (1-4or 5+) Cook's Assistant 6 Restaurant 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Maria Rodriquez Rosario UNK. 19b. Melling Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 21224 19a. Informant's Neme/Reletionship (Type, Print) Avis Crayton/Social Worker 4940 Fastern Avenue Mason Lorde Bldg. Baltimore, MD 200. Method of Disposition Data 200. Location - City or Town, Stata 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 ☐ Buriel 2 ☐ Cremeflon 3 ☐ Removel from Stete Metro Crematory, 4 Donetlop 5 ☐ Other (Specify) Inc. 3/10/00 Baltimore, MD 21. Signature of Funerel Service Licensas 22. Nama and Address of Fecility Edward & Cremation Society of MD, Inc. Fdward A. Gregorchik 299 Frederick Road Baltimore, MD 23a. Part 1. Enter the disaasa, or comblications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, intended to the control of the c 21228 Approximate Interval Batween Onsat and Death Immediate Causa (Finei alcoholism disaesa or condition resulting in deeth) Due to (or es e consequenca of): Dua to (or as a consequence of): Dua to (or es e consequenca of) Part fl. Other significant conditions contributing to death but not resulting in the underlying causa givan in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Wes an autopsy performed?

Physician /Medical Examiner

burial-transit

Physician/Medical

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Completed

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Medical

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physician s the burial

attending for use as

ed by the a

signed by

page 2

certificate

Hospital or Attanding Physician: 24 hours efter death. Funeral Director: After this certifica stelly filled in by the funeral director, g

24 hours

within 24 hou To the Fune completely fi To the

The law requires that the death certificeta be executed

P.O. Box 68760,

Records,

Division of Vital

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show must be notified at

"natural", or itams 23a

trsumstic event, the Medical Examiner

pernit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiane. Important: if tem 27 is marked other than "ready injury or other traumetic event, to a Made 2008.

Director

Funeral

by

Completed

Be

MD

the Marylend

death

Baltimore, Maryland 21215-0020

Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Ceuse (Diseese or injury that initiated events rasulting in death) Last

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 ☐ Yes 201No

5. Wes case retarred to medical				28. Plece	of Deeth (C	heck only one)	
exeminer?	Hospitel: 1 ☐ Inpatient	2 ER/Outpetienf	3□ DOA	Other: 4 Num	sing Home	5 Tasidance	6 Other (Specify)
7. Manner of Deeth	28a. Dete of Injury	28b. Time of	28c. I	Injury at	28d.	Describe how Inl	ury occurred

5 Pending investigation (Month, Dey Year) Work? 1 Neturel 1 Yes 2 No 2 Accident

3 Sulcide 6 Could not be 281. Location (Street end Number or Rural Route Number, City or Town, Stete) Pleca of fnjury - At home, ferm, straat, factory, office building, etc. (Specify) 4 Homicida

Certification: To 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) end manner stated. 29a. Certifiar

29b. Signature end titia of certifiar 29d. Dete signed (Month, Dey, Year) 29c. License number

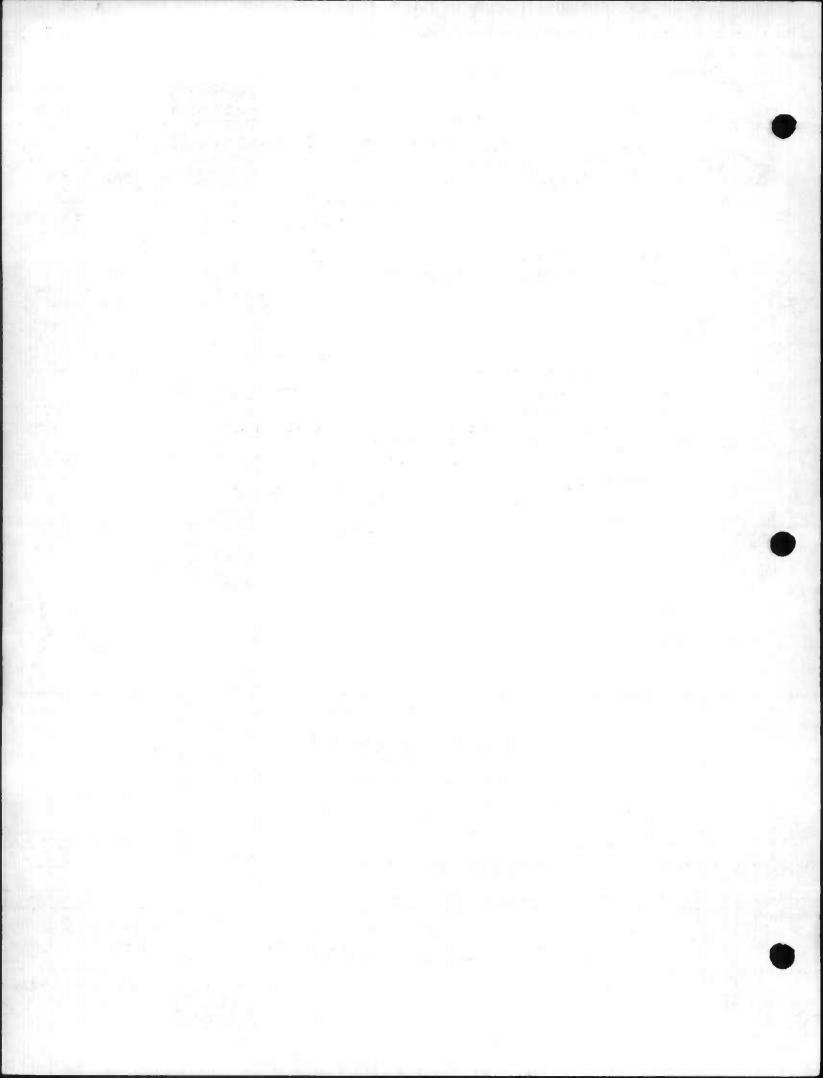
COOR

30. Name end eddrass of person who completed cause of deeth (Item 23e) (Type, Print)

Eastern Ave Baltwork MDZ1224 ~ LW Fredman MAR 15 32. Registrer's Signature

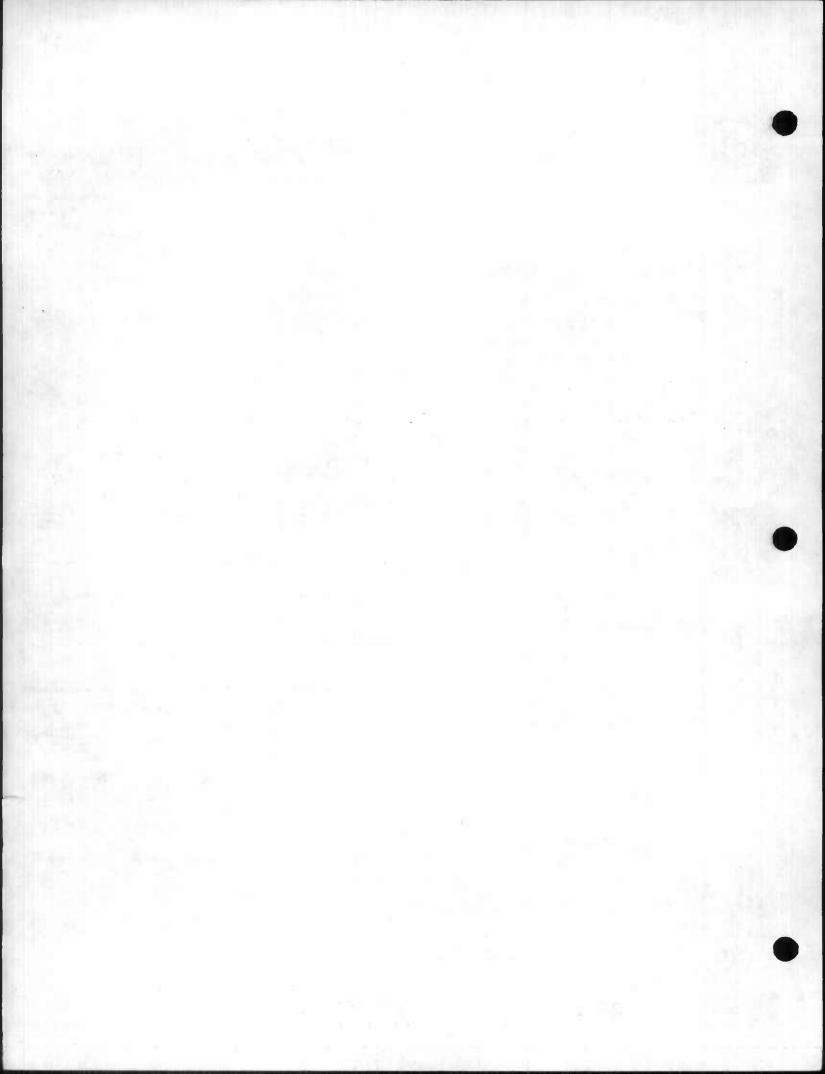
Susan 31. Date filed (Month

State Registrar



				Certi	ficate of	Death		Reg. No	o		8651
nysician	Decedent's Nama (First, Middle, La						2. Date of D Month	eath De	эу	Year	3. Time of Death
edical	Tonya Robin 4a Facility Nama (# not institution, giv		1			4b. City, Town, or Lo	MARCH cation of Dea		_2000		19:23 P
aminer	1100 WHITELOCK S			MENT 2		BALTIMOR			N/A	or Coour	
ral tor	5. Social Security Number 217-70-1635 Usual Rasidence of Decedent	Sax 7. A	ga (In yrs. Ia 41		If Under 1 Yaar Months Days	If Under 24 Hrs. Hours Min.	8. Data of Bi (Month, D OCT 3	rth ay, Year 1, 1		9. Birthple Country Mar	ce (State or Fore y) yland
	10a. State 10b. County		10c. City,	Town or Loca	tion					100	d. Inside City Limi
Director	MD N/A			Baltir							1 Yas 2□1
Dir	10a. Street and Number 1100 Whitelock	Street	#2D		10f. Zip Code 2121	7	16.0		USA	hat Countr	y?
Funeral	11. Maritai Status	12. Was Decedant	Evar in U,S	13. Wa		/ Hispanic Origin? (Spe lan, Mexican, Puarto	city Yas or N		14. Race	- America	
by	1 Nevar Married 2 Married 3 Widowed 4 X Divorced	Armed Forces' 1 Yes 2 If Yas, Giva Yaar or Datas:	No	10	Yas 2 No	Specify:	763		Specify:	R, White, at	
eter	15. Decedent's Ed (Specify only highest gra	ducation ade completed)		16a. Deceder (Give kir	nt's Usuel Occup nd of work done NOT use retire	pation during most of worki	ng	16b. Kind of Busi		siness/Indu	stry
Completed	Elementary/Secondary (0-12)	Collega (1-4or	5+)		ploved			N	/A		
Be	17. Father's Nama (First, Middle, Last,					18. Mothar's Name	(First, Middle	e, Maidei	Sumame	9)	
To	Cleve A. Plat					Marion E			omas		
	19a Informent's Name/Raiationship (Marion E. Platt					lock St.		-			
	20a. Mathod of Disposition		COL	ce of Disposit			Data	20c. Location			
	1 Burial 2 Cremation 3 4 Donation 5 Othar (Specif	Ramoval from Stata (y)		The state of the s		Inc. 3/1	4/00	Bal	timor	re, M	
	21. Signature of Funeral Service Liber	oree /		22. † Cr	lama and Addre	ass of Facility Society	of Mar				
	Edward A. Grego	orthik		29	9 Frede	erick Rd.	Baltim	ore,	MD 2	21228	
	23a. Part1. Enter the disease of com shock, or heart feilure. List only	plications that cause ona ceusa on aach l	d tha daath. ina.	Do not entar	tha mode of dyi	ng, such as cardiac o	or raspiratory	errest,		. 1	Approximate nterval Between Onset and Death
1	Immediete Causa (Finel	NARCOTIC	: TNTOXT	CATTON							
	disease or condition rasulting in death)	8.		es a conseque	nce of):			_		1	
miner		h —								i	
Exan	Sequentially list conditions, if any, leeding to immediata		Dua to (or a	is a conseque	nce of):						
	causa. Entar Undarlying Cause (Disease or injury that initiated evants	c	Dua to (or a	s a conseque	nce oft:					-	
	rasulting in death) Last										
Medi		0.								1	
ian/Medi			out not result	ing in tha und	erlying causa gi	ven in Part I.					the cause of dear
nysician/Medi	Part II. Other significant conditions of	contributing to death t						Yas	2 No	3 Probi	ably 4 ☐ Unkno
by Physician/Medical	Part II. Other significant conditions o	contributing to death t						7		24h Wer	a autopsy finding lable prior to
by	Part II. Other significant conditions of	contributing to death t					24a. Wa	s an auto	opsy	avai	
by	Part II. Other eignificant conditions o	contributing to death b					24a. Wa		opsy	com	pletion of cause eath?
Completed by		contributing to death t					24a. Wa peri	Yas 2	opsy	com of de	pletion of cause
Be Completed by	25. Was case referred to medical examinar?	Hospital:			ST DOA ON	26. Place of Death	24a. Wa peri	Yas 2	2□No	avai com of d	pletion of cause eath? Yes 2 No
To Be Completed by	25. Was case referred to medical examinar? Y☐ Yas 2☐ No 27. Mannar of Death	Hospital: 1 □ Inpati	ent 2 E	R/Outpatient 8b. Time of	3LI DON	her: 4 Nursing Ho	24a, Wa peri	Yas 2	2 □ No 6 □Othe	avai com of de 1	pletion of cause eath? Yes 2 No
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edical Certification: To Be Completed by	25. Was case referred to medical examinar? Yas 2 No	Hospital: 1 Inpati 28a. Data of Inj. (Month, Da found 3/9/ 28a. Placa of In building, a found at systetan: To the best	ent 2 E ury 2 y Year) f (0) jury - At hom to. (Specify) CPS106 of my knowl of examinetic	8b. Time of Injury OUN 17: 00 10 10 10 10 10 10 10 10 10 10 10 10	P 28c. Inju Wo 1 L. t, factory, office	her: 4 Nursing Ho iny at ink? 1 Yas 2 XNo ime, date end place, a opinion, death occurr se number	24a. Wa per 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Yas 2 one) sidence how inju (Street e own, Stell e, M 2 cause(s, date er	6 Other occurrence of Number of Numb	or (Specify) er or Rural White	pletion of cause sath? Yes 2 No ect ingest Route Number, lock Street ted. tha cause(s)

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** 2000 /Medical 4 City, Town, or Location of Death Examiner If Under 1 Year 7. Age (In yrs. last birthday) (State or Foreign **Funeral** 10 M 20 F Director 10a. State City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show the Medical Examiner must be nothled at 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code USF Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11 Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 WYes 2 No If Yes, Give Year or Dates: Black Baltimore, Maryland 21215-0020 1 Yes 20 No Specify Specify: À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. PO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mentel Hyglene. Important: if Item 27 is marked other than "na any Injury or other traumatic event, ma Head page. Elementary/Secondary (0-12) 17\ Father's Name (First, Middle, Last, Mother's Name (First, Middle, Be Informent's Name/Relationship (Type, Print) atonsville, MD. 20b. Place of Disposition (Name of 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 21229 completions that caused the death. Do not only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical death Sudden **Examiner** Examiner Arrhythma the buriel-transit pue Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last erde vasculen diease artherosclerustre (Box 68760 Physician/Medical Due to (or as a consequence of) Arcelutes mulitus P.O. F Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sate has been signed by the page 2 should be detached 3 Probably 4 Unknown 1 Yes 2 No Kerelein renal Records, þ 24b. Were eutopsy lindings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yas 2 No certificate 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physicien: Within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Daath 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar 29b. Signature and title of certifier

Kniel

North 31. Date liled (Month, Ran Year) 1 5 200 32. Registur's Signature

30. Name and address

DHMH 16 Rev 6/95

ORIGINAL

who completed cause of death (Item 23a) (Type, Print)

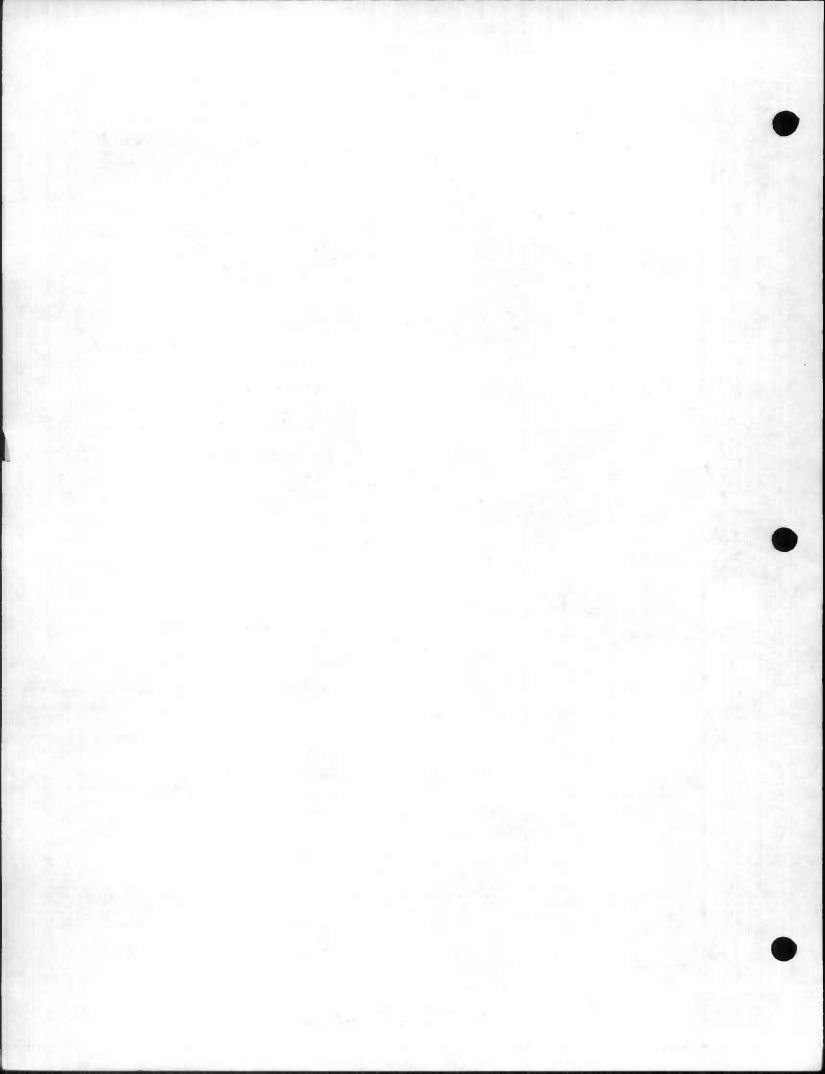
29d. Date signed (Month, Day, Year)

29c. License number

3-13-00

31927

MD 21045



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Nama (First, Middle Las 2. Data of Death **Physician** /Medical Town, or Location of Death **Examiner** Undar 24 Hrs. Birthplace (State of Foreign **Funeral** Days 10 M 200 F Director Usual Residence of IOc. City, Town or Location 10d. Inside City Limits ahow must be notified at 1 TYes 2 No Director or 28a-f 10g. Gitizen of What Country? 238 Funeral Hems Race - American Indian, Black, White, etc. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after not of Health and Mental Hygione. Interfit item 27 is marked other than "natural; or the ury or other traumatic event, my Mental is a marked only in Mental in the ury or other traumatic event, my Mental is a mine. 1 ☐ Yas 2 TNo If Yas, Giva Yaar or Datas: 1 Nevar Marriad 2 Married 21215-0020 1□Yes 212No λq 3 1 Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Baltimore, Maryland 17. Fathar's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnama) Be 5 2 Depertment of Health and I important: if Item 27 is me any injury or other traums Informent's Name/Ralationship (Type, Print) 20b. Place of Disposition (Name of 20a. Mathed of Disposition 1 Burial 2 □ Cremation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) permit. 21. Signatura of Fun ral Same Licenses MD.212ag a, or complications that caused the daath. Do not enter List only ona cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Causa (Final Neuman disaasa or condition rasulting in death) Week Examiner Physician/Medical Examiner 5205e cars The law requires that the death certificate be executed Sequantially list conditions, if any, laading to immadiata cause. Entar Underlying Causa (Disease or injury that initiated evants rasulting in daath) Last pue Dua to (or es a consequence of): the bunai-trar Box 68760. Dua to (or as a consequence of): SE USB signed by the atter Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of deeth? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? has page 2 certificeta 1 Yes 1 ☐ Yes 2 ☐ No Attending Physician: funeral director. Be 25. Was casa refarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Certification: To 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Day Year) 27. Mannar of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending Invastigation 1 Natural deeth. 1 Tyes 2 No 2 Accidant i or Attend after deeth Director: the 3 Suicida 6 Could not be datarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida To the Hospital within 24 hours a To the Funeral D 152 entifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the best of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medicai 29a. Cartifiar completely (Check only one) 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) 29c. License number MAR 10 217118 2000 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)

State Registrar 31. Dete filed (Month, Day, Year) MAR 1 5

DHMH 16 Rev 6/95

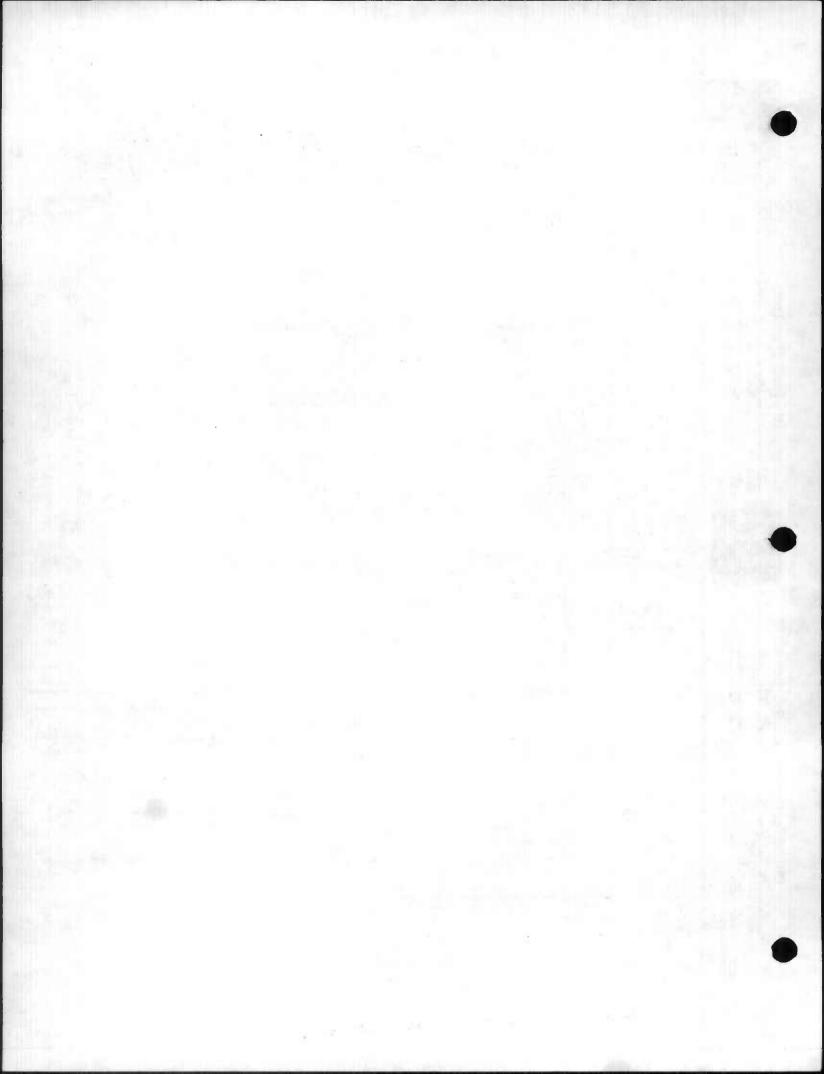
ORIGINAL

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32. Registrar's Signature

21212

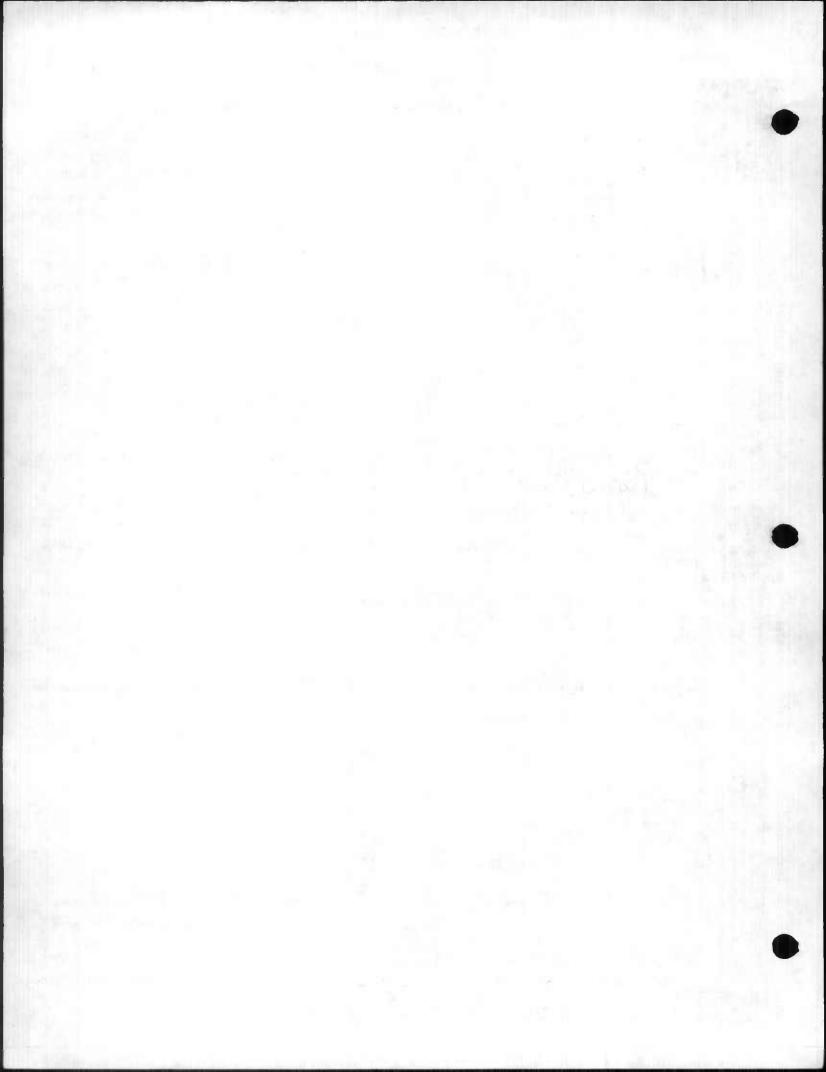
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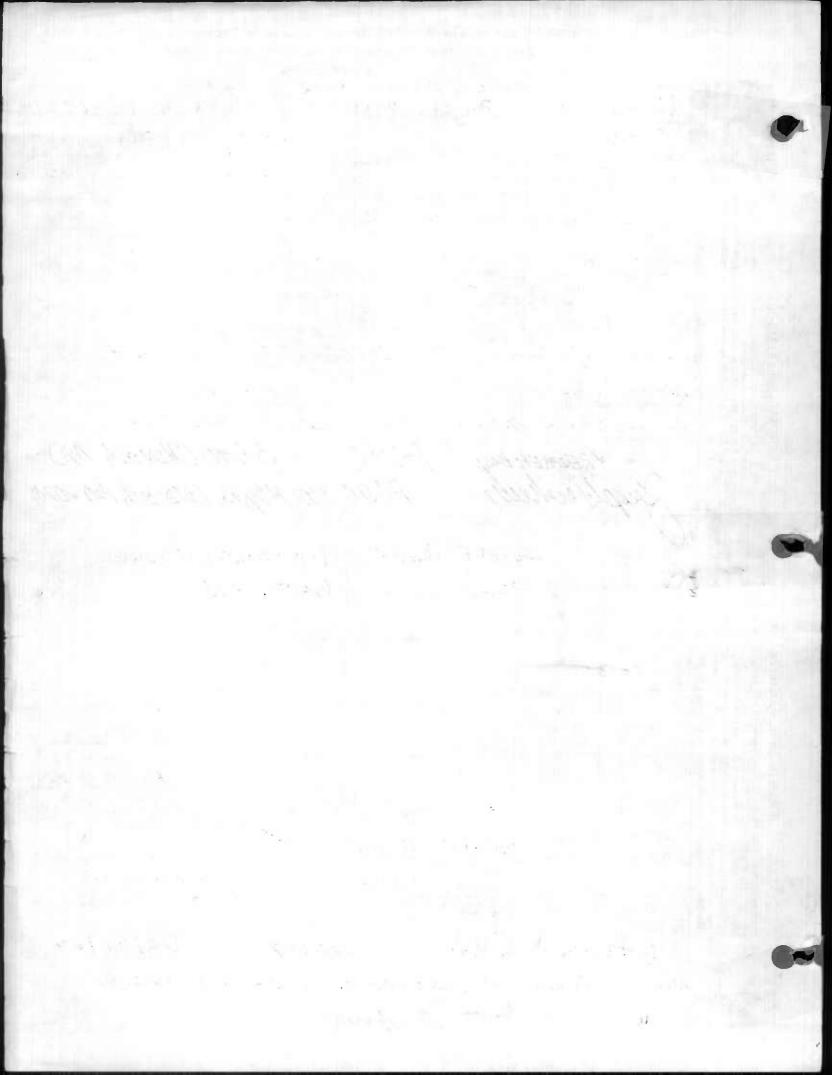
State of Maryland / Department of Health and Mental Hygiene

O 8 6 5 L

				Certific	ate of	Death		Reg	. No.	U	4000
Physician	1. Decedent's Name (First, Middle, La	st)					2. Dete	of Death	Day	Year	3. Time of Death
/Medical	Audrey	Aileen	Romagi	nano				ARCH			12:20 P
xaminer	4a Facility Name (If not institution, given Saint Joseph		Cente	r			n, or Location of	f Death	4c. County		imore
uneral rector	215-30-9019	Sex 7. Age	(In yrs. last bi	Yrs. If Un	der 1 Year hs Days	Hours Hours	Min. (Mor	of Birth oth, Day, Youne 17	ear)		ce (Stete or Foreign y) yland
NA MAIN	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location						10	d. Inside City Limits
rector			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1.					1 ☐ Yes 2 ☒ No
Director	Maryland Baltin	nore			ysvil Zip Code	Te		100	. Citizen of W	Part County	~2
				101.		000		109	. 01120110111		y:
era	11107 Pool Road	12. Wes Decedent E	ver in U.S.	13 Was De		030	n? (Specify Ver	or No.	14 Bace	USA - America	n Indian
by Funeral	1 Never Married 2 Married 3 ☑ Widowed 4 Divorced	Armed Forces? 1 Yes 2 No If Yes, Give A Year or Dates:				an, Mexican, Specify:	n? (Specify Yei Puerto Rican, e	tc.)		k, White, el	
Completed	15. Decedent's E		16a	. Decedent's U	Isual Occup	pation		16	b. Kind of Bu	siness/Indu	istry
D.	(Specify only highest gra Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NO	Work done T use retire	during most o	or working				
E	12	n/a	'	Ноп	emake	r			Ov	vn Hor	me
BeC	17. Father's Neme (First, Middle, Last,)				18. Mother's	s Name (First,	Middle, Mai	iden Sumem	9)	
10 8	Gotleib	Fleig				He1	en		Stempo	or	
	19a. Informent's Neme/Reletionship (198	b. Mailing Add	ess (Street	and Number	or Rural Route		-		Code)
	Dennis M. Romagna	no/Son					, Timor			1093	
To	20a. Method of Disposition	ino / Bon	20b. Place o	of Disposition (Name of		Date		c. Location -		m, State
3	1 Burial 2 Cremetion 3			ry, crematory			2/10	100	D = 1 + 1 -		Manual a. 1
	4 Donetion 5 Other (Specifical Survival Liquid		Bohem				y 3/16	700	Baltin	nore,	Maryland
eny injury or other tre	Bryah W. Clar	any)	Le	mmon		1 Home Road,	Timon	nium, N	4D 2	1093
	23a Parti Enter the disease, or com shook, or heart leiture. List only	plications that caused to one cause on each line	he death. Do	not enter the r	node of dyi	ng, such as ca	ardiac or respira	atory arrest		. 1	Approximate Intervet Between Onset and Deeth
ian ical	Immediate Cause (Finet	SUBARA	CHNOT	D DEMO	אשמר	VCE.					HOURS
ner	disease or condition resulting in death)	aa.	ICHIAO T	ח חבווו	אנואאנ	105				1	האטטה
5		0	ue to (or as a	consequence	of):						
Examiner	Sequentially list conditions,	b	ue to (or as a	consequence	of):					i	
i i	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c									
iclan/Medical Examir	resulting in death) Last	D	ue to (or as a	consequence (of):					1	
Physician/		0.								1	
18	Pert II. Other significant conditions of	ontributing to death but	not resulting i	in the underlyir	g cause gi	ven in Pert I.	23	b. Did toba	cco uae con	tribute to	the cause of death?
by Physic								1 🗆 Yea	2□ No	3 Prob	ably 4 X Unknown
, pege 2 should be del Completed by P			11				248	a. Was en e performe		com	e autopsy lindings lable prior to spletion of cause eath?
E								1 Yes	2 No	10	Yas 2 No
ŏ o	25. Was case referred to medical					26 Place	of Deeth (Check				
I director, peg To Be Co	axaminer? 1 ☐ Yes 2 🛣 No	Hospitel: 1 Inpatien	2 □ EB/O	utpatient 3	DOA ON	.00	sing Home 5		o € □Othe	v (Snacihi	
	27. Manner of Death			Time of	28c. Inju		7		injury occurre		
	1 Netural 5 Pending investigation	28a. Date of Injury (Month, Day	Year)	Injury M		rk? Yes 2 □ N	100		,,		
Certification:	2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined		y - At home, fe (Specify)				28f. Loc	ation (Street or Town, S		er or Rural	Route Number,
completely filled in by the funeral Medical Certification:	29e. Certifier 12 Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of niner: On the basis of e and manner state	xamination an	e, death occur nd/or investigat	red at the ti	me, date and pinion, death	place, end due occurred at the	to the caus time, date	se(s) end ma and place, a	nner as sta and due to t	ited. the ceuse(s)
Me M	29b. Signature end title of certifier			MINT	29c. Licens	e number		29d	. Date signed	(Month, D	lay, Year)
1	Rical	· Lwt	icuu.		D318	326			-12-	3410011	
X	20 Name and address			G 5				1			
D	30. Name and address of person who RICHARD L. LI	completed cause of dea			OSLE	R DRI	VE, T	OWSOI	V, MAI	RYLAI	ND 21204
State	31. Date liled (Month, Day, Year)	32. Registrar		7.	10	4 .	,				
Pamiatuan	1100 1 E	2000 1/20	aid a punched	23	Ann	Kal					



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Nama (First, Middle, Last) AMELIA IWULA REED 3. Time of Death 2. Date of Death Month Year **Physician** child of Angela MARG t-emale 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PAHC neverh PG If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 218 F Months Days Hours Yrs. Director 16 VONE Usuai Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. fnsida City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at 1 Tes 2 No HSVILLE Director GEORGES PRINCE MARYLAND 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 3600 20784 Funeral 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 Yes 2 No Specify: Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced IACK Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d 2 should be filed within 7, th and Mental Hygiene. 7 is marked other than "nu Elementary/Secondary (0-12) College (1-4or 5+) NFANI NFANTI LNHAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be and 2 should be William ANDRE HNGELA KENER 19a. Jofgrmant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a important: If Item 27 is any injury or other training. Heverly, mo. 3001 Rince beonges HUSPITAL 4051 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, State Pages 1 Buriai 2 Cremation 3 Remoyal from State 4 Donation 5 ретіт. Pa /1. Enlight the disease, or complications that ceused the death. Do not enter tha mode of dying, such as cerdiac or respiratory arrespoke, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Ceuse (Finei - IMMATURITY AT 22 WEEK disease or condition resulting in death) Examiner Examiner be executed attending physician end for use as the bunal-tran Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or injury that initieted events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical certificate Due to (or as a consaquance of) 88 23b. Did tobacco use contribute to the cause of death? ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Completed peen : has page 2 1 ☐ Yes 2 No 1 Yes 2 No certificate funeral director, 25 Was case referred to medical Be 26. Plece of Death (Check only one) Hospitai: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this 28a. Date of Injury (Month, Dey Year) 28c. Injury al Work? 28d. Describe how Injury occurred 27. Menner of Death 28b. Time of 1922 pm Natural 5 Pending 03/04/00 1927 pm 10 28e. Piaca of fnjury - At home, farm, street, factory, office building, etc. (Specify) 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 ☐ Homicide cloverh PAHC 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the cause(s) and maker as steted. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 3001 HOSPITAL DRIVE, CHENELY, MD 20785 K. FOINWFOOD (mi) ANTOINE 2. Registrar's Signature 31. Data filed (Month, Day, Yeer) State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Year HUBINSON 03.58 Am 2000 March 4b City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) 13 Cultimore if Under 24 Hrs. 8. Date Home if Under 1 Year t. Age (In yrs. last birthday) peciality Potos Birthplace (State or Foreign Country) F 5. Social Security Number 1 M 2 F Months Days 217-078-101A Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 ☐ No 1d MI 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20 HI SA Stree 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Biack, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) American Indian 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2⊟Ne 1 Yes 2 No Specify: Specify: 3 ₩idowed 4 Divorced ack 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 841 10 mests Homeme 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bourne urence 20011730 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 0 Dath more, Edwards 1d OUISP 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 → Buriai 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 1639 P Barro 438 Len of the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, heart tallure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final · CONGESTIVE HEART FAILURE disease or condition resulting in death) 2 months Due to (or as a consequence of): CORONARY ALTERY DISTAJE Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of) that initieted events resulting in death) Last Due to (or as a consequence of) Part ii. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Onknown CHRUNIC REMAL PAILVALE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work?

be executed pue burial-tre attending physician for use es the burial ata has been signed by the page 2 should be detached Division of Vital Records, law requires certificata has The state of the Physician: director, this funeral After Attending deeth To the Hospital or Attend within 24 hours efter deet To the Funeral Director:

Physician/Medical Completed Be To Certification: filled in by

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Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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0

Examiner

7 is marked other than "natural", or items 23s or 25s-1 show traumatic svent, tra Maxical Examinar maint be notified as

the Marylend

death

72 hours after

12 should be filed within 7: n and Mental Hygiana. Is marked other than "n

permit. Pages 1 end 2 should be 1 Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic avea

Physician

Examiner

27. Manner of Death Natural 2 Accident 3 ☐ Suicide

29a. Certifier

(Check only one)

1 Yes 27 Ho 4 - Homicide

25. Was case referred to medical examiner?

5 Pending investigetion

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

MD

march 12 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARISALEENIND 9101 FRANKLIN SQUARE ORIVE, BALTIMORE HARISALEEMIMO

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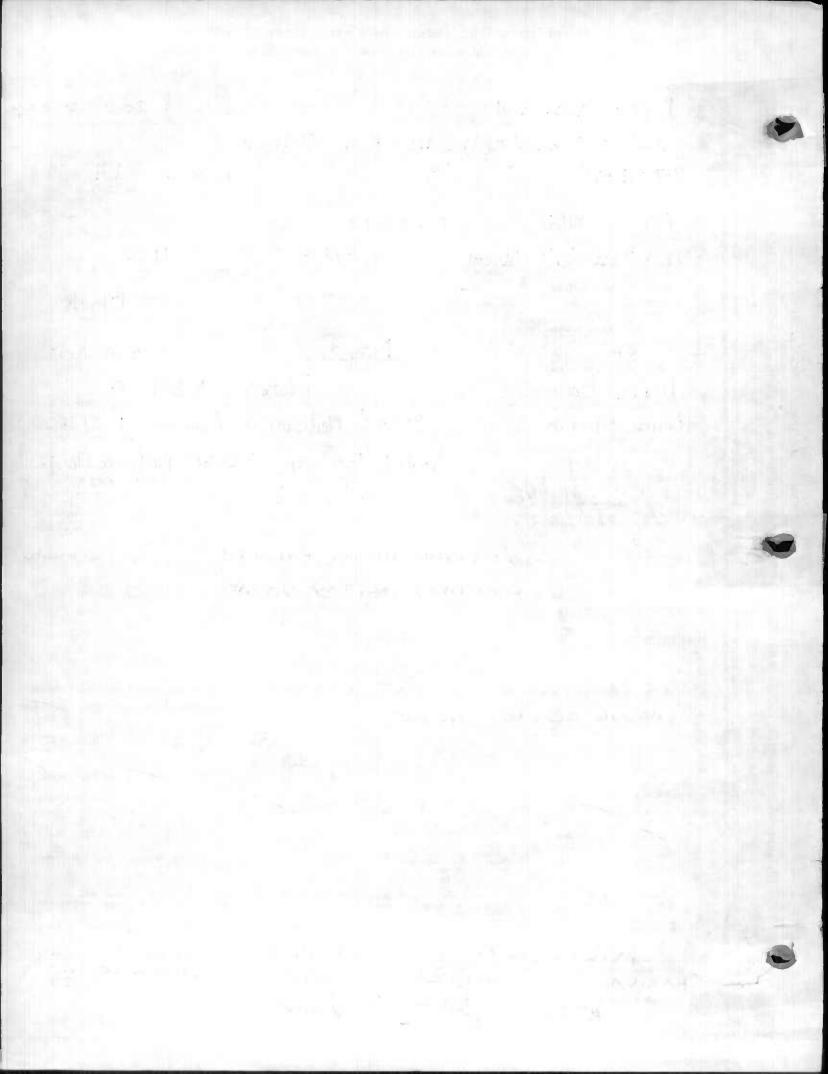
State Registrar

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completely

31. Date filed (Month, Day, Year) 32. Registra's Signature MAR 15 2000

2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.



3. Tima of Deeth

Birthplace (State or Foreign Country)

10d. Inside City Limits 1 ☐ Yas 2 No

Baltimore

USA

Black, White, etc.

White

7:50 PM

RAGLAND

March 13,

r 28a-f show notified at ahow ò Barns 23s "natural", or han dical Examinar March 13, Hygiene. Baitimore, Maryland 2121 1 and 2 should be Health and Mental Ragland

Physician

/Medical

KELLY

ASBORNE

4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F Months 82 227-10-1951 Director Usual Residence of Decedent 10a. Stata 10b. County 10c, City, Town or Location Directo Rosedale Md. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8421 Coco Rd 21237 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. 11. Merital Stetus 1 A Yas 2 No If Yes, Give Year or Dates: WW-] 1 Never Married 2 Merried 1 Yes 2 No Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Bethleham Steel Brick Layer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Willie Rock Ragland John 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and. Department of leasth a Important: if them 27 is, any injury or other and any injury or other any injury or other any injury or other and any injury or other any injury o 8421 Coco Rd. Rosedale, Md. 21237 Mrs. Ruth R. Ragland/wife 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) American Legion Cemetery 3/18/00 East Stone Gap, Va. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. 21. Signeture of Funeral Service Licens 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical COLON CANCER Examiner Due to (or es e consequence of): Physician/Medical Examiner physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of): 68760 that initiated events resulting in death) Last Due to (or as a consequence of): Box use P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ Completed 24a. Wes an autopsy performed? of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director; is Be 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 Yes 2 No edical Certification: To 28c. Injury at Work? 27. Manner of Death Division 5 Pending investigation 1 Natural a after dea. 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one) 29b. Signatura and title of certifier 29c. License number

Approximate Interval Beh Onset and Deeth 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 TYas 2 No Other: 4 Nursing Home 5 Residence 8 MOther (Specify) HOSPICE 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29d. Date signed (Month, Dey, Year) 14/00

State Registrar

31. Dete filed (Month, Day, Year) MAR 1 5 2000

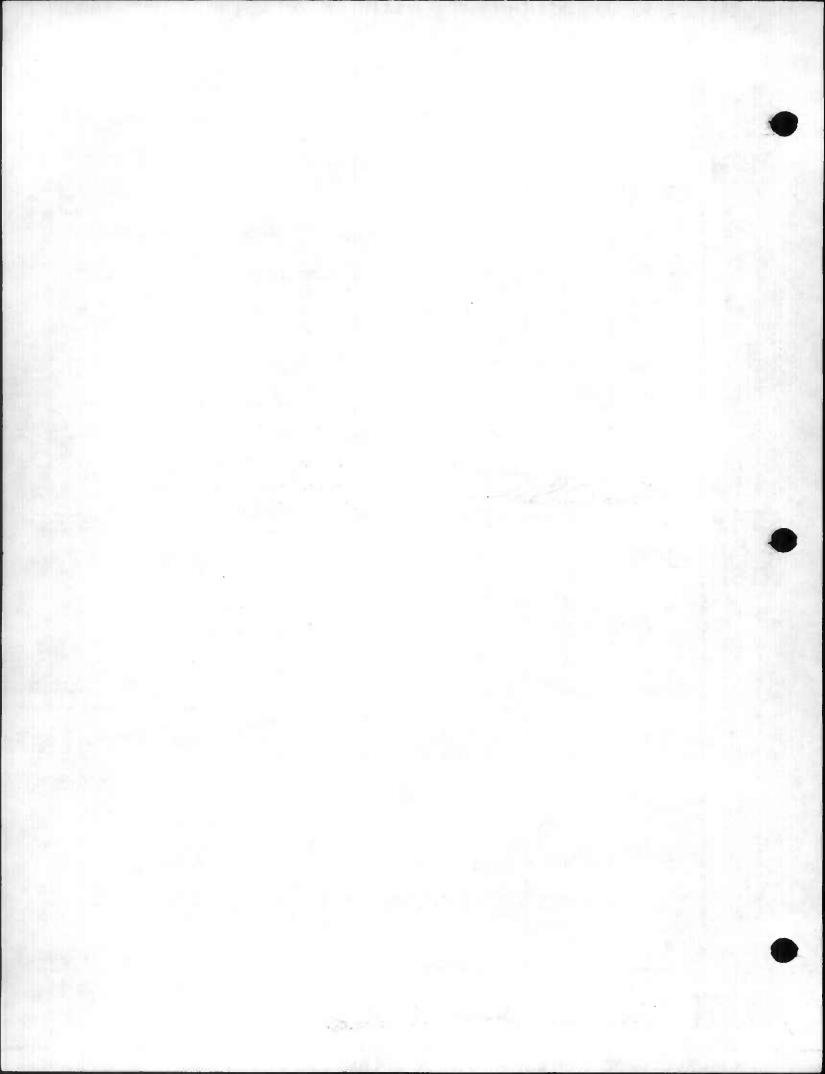
DR. TARIQ MAHMOOD

2300 DULANEY VALLEY RD. 32, Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

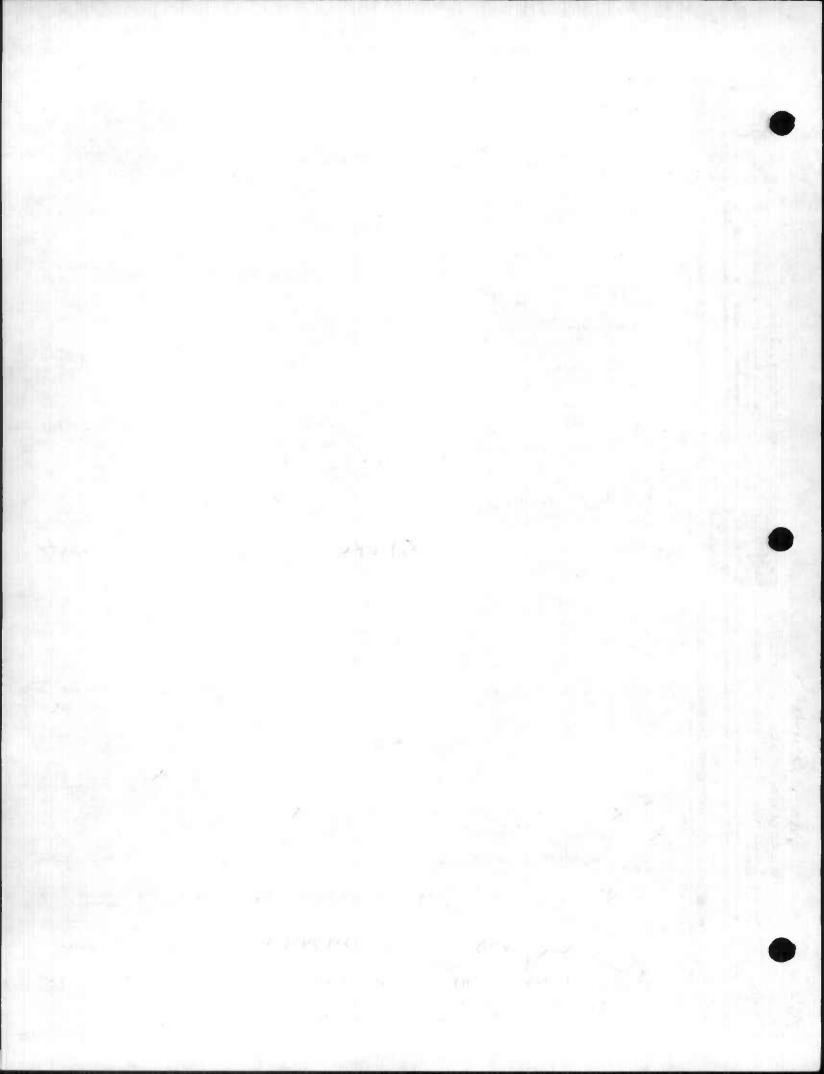
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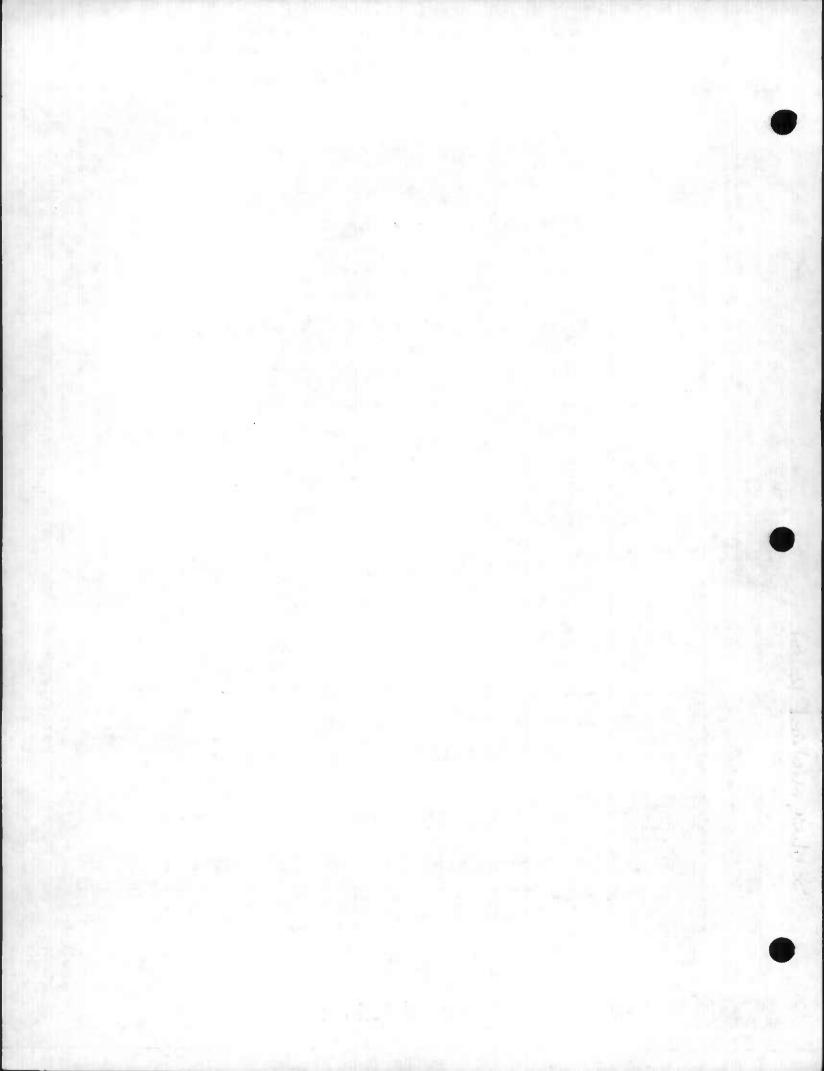
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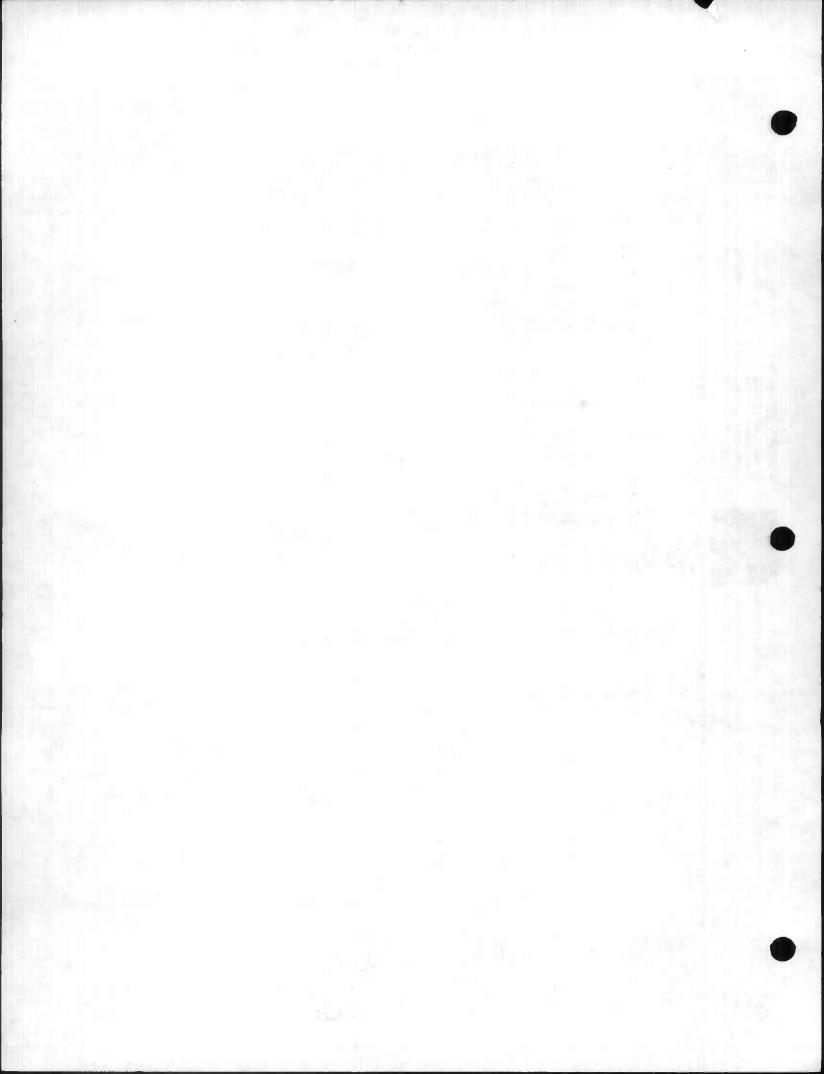


State of Maryland / Department of Health and Mental Hygiene 0 865

	Certificate of Death	Re	eg. No.	00000
Dhysisis	1. Decedent's Nama (First, Middle, Last)	2. Date of Death Month		3. Time of Death
Physicia /Medic	michael Robert Schiber, Sr.	MARCH	13 20	2323
Examin	4e Facility Nama (If not institution, give street and number) 4b. City, Town, or L		4c. County of	Death
	St. Agnes Hospital Baltimo 5. Social Security Number 6. Sex 7. Age (in vrs. last birthday) if Under 1 Year If Under 24 Hrs.		N/A	
Funeral Director	215-03-7385 12 M 2 F 91 Yrs. Months Days Hours Min.		1908 M	Birthplace (State or Foreig Country) aryland
P 2-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
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Te, No. 1 and It Health Hem 27 other tr	Anthony L. Zentgraf/Son-in-law 7 White Sail Circle, B			
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	23a. Part I that the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory arra	ast,	Approximate interval Between
2 2 2	Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):	erctor		
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Vision of Attending Phys or death. ector: After this by the funeral di		28d. Describe ho	w injury occurred	
Division of National Artending Physics afterdeath After this collector: After this colled in by the funeral dire	27. Manner of Death 1 Production 2 Accident 3 Suicide 4 Homicide 28e. Date of Injury (Month, Day Year) 28e. Place of Injury 3 Suicide 4 Homicide 28e. Place of Injury 3 Home, farm, street, factory, office 29e. Certifier (Check only one) 29e. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place of Injury 29e. Certifier (Check only one)	28f. Location (Sti City or Town	reet end Number n, Stete)	or Rural Route Number,
To the Hospital of within 24 hours at To the Funeral D completely filled it	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place of the place	, and due to the ca irred at the time, de	ause(s) end mann ate and place, and	ner as stated. If due to the cause(s)
o the	≥ 29b. Signature and title of certifier 29c. License number	2	9d. Data signed (Month, Dey, Year)
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0	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITINE Solvername MD 900 Cets A	venue 1	Balt.	7.1770
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	Physician	1. Decedent's Neme (First, Middle, Li	ast)	Smith	ato or E	Journ	2. Date of Deat Month	h Day	Year 3.	Tima of Death				
	/Medical	Sherri 4a Facility Name (II not institution, gi	Diane		48	b. City, Town, or Loc	MARCH ation of Death			2200 PM				
	Examiner ———•	LAUREL REGIONAL	HOSPITAL			LAUREL		PRINC	CE GEOR	GES				
	Funeral Director		Sex 1 M 2 F 7. Age (In yrs. 38	Yrs. If U	nder 1 Year ths Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 1962	9. Birthplace Mary	(State or Foreign				
	death with the Maryland rms 23s or 28s-f show r must be nodified at neral Director	10a. State 10b. County	A 1 /	y, Town or Location	220					Inside City Limits				
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	riter death with the Ma ritems 23s or 28s-1s in ar must be notified Funeral Director		bad way #	101		213		U	S.A	,				
	ors after or, or he by Fu	11. Maritel Stetus 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates:		ecedent of His specify Cubar is 2 No	spanic Origin? (Spen, Mexican, Puerto F Specify:	cify Yes or No- lican, etc.)		e - American Ir sk, White, etc. : Bla	ndian,				
15-0	n 72 h natur edical	15. Decedent's E (Specify only highest gr	ducetion ade completed)	16a. Decedent's (Give kind o	Usual Occupa f work done di OT use retired)	uring most of working	9		usiness/Industr					
212	ed within 72 ho ygiene. or than "natura ft, fre Medical!	Elementary/Secondary (0-12)	College (1-4or 5+)	1 -	ary	Cook		Nu	rsin	9				
Maryland 21215-0020	s 1 and 2 should be filed if Health and Mental Hygicitam 27 is marked other other traumatic avant, if To Be Co	17. Father's Name (First, Middle, Last	()		1500	18. Mother's Name		faiden Sumam	ne)					
Aary	2 should and M la mar raumat	19a. Informani's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
re,	Health tem 27 other to	Dartene Glover - Aunt 819 N. Kenwood Ave. Bacto. nd. 21213 20a. Method of Disposition (Name of Date 20c. Location - City or Town, State												
Baltimore,	y or	1 Buriel 2 Cremation 3 4 Donation 5 Other (Special												
Balt	permit. Pa Departmen Important: any injury phice.	21. Signature of Funeral Service Lice	Mayrow		831	2 Lib	erry Ro	ad. Ba	en fune Sto. Md.	ral Senide 21244				
	Physician /Medical Examiner	23a. Part 1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final diseasa or condition resulting in death)	CARDIAC ARRHY CARDIOVASCUL	THMIA IN	ASSOCI SE				Inte	proximate rivel Between set and Deeth				
	executed n and ial-transit Examiner		b											
90,		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (o	r as a consequence	of):									
x 687	5 g 2	Cause (Diseese or Injury that Initiated events resulting in death) Last	Due to (or	r as a consequence	of):									
	at the death certified by the attending etached for use a Physician/M	Part II. Other algnificant conditions of	contributing to death but not resi	ulting in the underlyi	ng cause give	n in Part f.	23b. Did to	bacco use co	ntribute to the	cause of death?				
۵.	ras that the igned by the be detached by Physical by P	ACQUIRED IMMUNOD	EFICIENCY SYNDR	OME. BIPC	LAR DI	SORDER	1 🗆 Yı	a 2 No	3 Probably	y 45 Unknown				
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ai B	certificate has rector, page 2	05 W					15/1/		XXY	s 2 No				
Ž.	2 0 0	25. Wes case referred to medical examiner? 1 XX es 2 □ No	Hospitel: 1 Inpatient 2 💢	BR/Outpatient 3	DOA Othe	26. Place of Deeth			er (Specify)					
o uc	After this funeral di	27. Manner of Death 1XXNetural 5 Pending	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at 2	8d. Describe ho							
Divisio	To the hospital or Attanding by within 24 bours after death. To the Funeral Director: After th complately filled in by the funeral Medical Certification: Medical Certification:	2 Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Injury - At home, farm, street, fectory, office building, etc. (Specify)								ute Number,				
	to the Hospital or Attant within 24 hours after decided To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only 27 Medicat Example 10 Certifying Processing 10 Certifying 1	nyafclan: To the best of my knowning. On the basis of examination	wiedge, death occur tion and/or investiga	red at the time tion, in my op	e, date and place, e inion, deeth occurre	nd due to the ca d at the time, da	use(s) and me ate and place,	enner as stated and due to the	l. cause(s)				
	within To the comple	29b. Signature and title of certifier	The		29c. License O.C	number .M.E.	25	MARCH	d (Month, Day,	Year) 2000				
		30. Neme and address of person who FOR JOSEPH PESTAN		Penn Str	eet, B	altimore.	Maryla	nd 2120)1					
T	State Registrar	31. Date filed (Month, Day, Year) MAR 1 6 7	32. Redistrar's Signa	ture	1 .		2							
DHM	H 16 Rav 6/95	Tan 0 ·		- 4	porks									

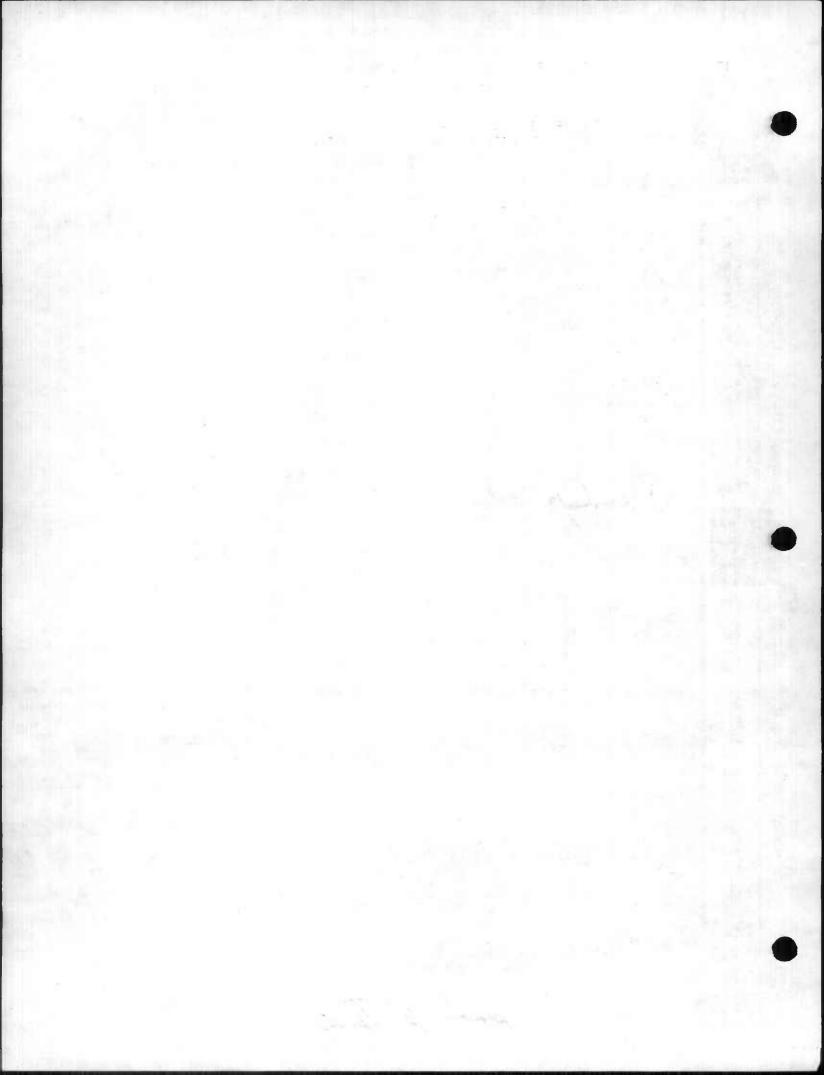
ORIGINAL

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 00-1425-510 State of Maryland / Department of Health and Mental Hygiene eddie Smith 08662 JVW AMEND ITEM: #4A ,2 PER MEO G781 3-17-200) WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death 3-12-2000 **Physician** Eddie Leamond Smith 13,2000 02:44A.M. March /Medical 4a Facility Name (If not in etitution, nive street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harbor Hospital UNIVERSITY OF MARYLAND MEDICAL CENTERAL TIMOTE 5. Social Security Number 8. Date of Birth Month Day, Year 77 9. Birthplace (State or Foreign Country)

Naryland 7. Age (In yrs. last birthday) **Funeral** Days 12M 20 F 216-90-8695 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits I hygiene. other than "natural", or hems 23s or 28s-f show vant, the Medical Examination notified at N/A Yes 2 No **Baltimore** Director 10e. Street and Number 10g. Citizen of What Country? 231 North Calhoun Street Apt. 301 21223 TISA Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Rece - American Indian Black, White, etc. filed within 72 hours after 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Black Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Second 12th ondery (0-12) College (1-4or 5+) Cook Restaurant 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Nem 27 is marked other
any Injury or other traumatic avant Be Eddie L. Smith Maria Singletary 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 231 North Calhoun Street Apt. 301 Balto, Md 21223 Maria Singletary (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlai 2 □ Cremation 3 □ Removal from Stete Mount Zion Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 3/17/2000 Lansdowne, Maryland 22. Name and Address of Facility Caple Funeral Service 5502 Winner Avenue Baltimore, Maryland 21215 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximete fnterval Between Onset end Deeth **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) **Examiner** Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): 68760. Physician/Medical Due to (or as a consequence of): Box 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. a No 3 Probably 4 Unknown Records, à 24b. Were autopsy findings available prior to Completed 24a, Was an autopsy completion of cause of death? 2 🗆 No Ves 2 No Division of Vital Be 25. Was casa referred to medical examiner? 26. Place of Deeth (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) XXYes 2 No 1 Inpatient 2XXER/Outpatient 3□ DOA 1 27. Menner of Death 28a. Dete of Injury (Mbnth, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. tnjury st Work? Certification: Affac 1 Natural 5 Pending 107 investigation 100 0150 1 Yes 2 Accident after deal Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 45 Homicide 8 24 hours • Funeral 29a. Certifier Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. (Check in one) To the 2 within 2 To the i 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 13,2000 and address of person who completed cause of death (Item 23a) (Type, Print) ALON 20) 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Dete filed (Month, Dey, Year) State MAR 15 Registrar

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08663. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 13 20/2/2 9 25 PM 4c. County of Death EDNA DOROTHY STRICKER 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Saint Joseph Medical Center Towson Baltimore If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 10 M 20 F Yrs. 216-28-6968 March 21 1912 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2 ☑ No Baltimore Phoenix 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 3 Doe Ct. 21131 USA 11 Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: White Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 n/a Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Tinley Daisy Downey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris M. Eiring/daughter 3 Doe Ct., Phoenix, MD 21131 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 31/16/00 Baltimore, MD 22. Name and Address of Fecility 21. Signatu Lemmon Funeral Home 10 W. Padonia Rd., 1 Michael A Flagle Timonium, MD 21093 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) RESPIRATORY FAILURE Due to (or as a consequence of): CHRONIC OBSTRUCTIVE LUNG DISEASE Due to (or es e consequence of): Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to 24a. Was en eutopsy performed? completion of cause of death?

Physician /Medical Examiner

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> 8.6 for use as USB

signed by the a

peed

certificate

this funeral

After

To the Hospital or Attending within 24 hours after deeth.

To the Funeral Director: After completely filled in by the fun.

director.

Completed

Be

Certification: To

Medical

The law requires that the death certificate be executed

Box 68760.

Records, P.O.

Division of Vitai Attending Physician: **Physician**

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Examiner

Director

Funeral

þ

Completed

88

Funeral

Director

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23a or

or Nems

Pages 1 and 2 should be Illed within 72 hours after nent of Health and Mental Hydjans.
Int. If Item 27 is merked other than "natural; or its iny or other traumals event, the Medical Examines iny or other traumals event, the Medical Examines.

altimore, Maryland 21215-0020

with the Maryla

Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical 2

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 1 Tyes 25 No

25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 18 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. tnjury at Work? 5 Pending 1 Netural 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29e. Certifier

(Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated.

D37254

29b. Signeture and title of certifier

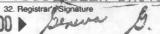
29c. License number 29d. Date signed (Month, Day, Year) 3/14/00

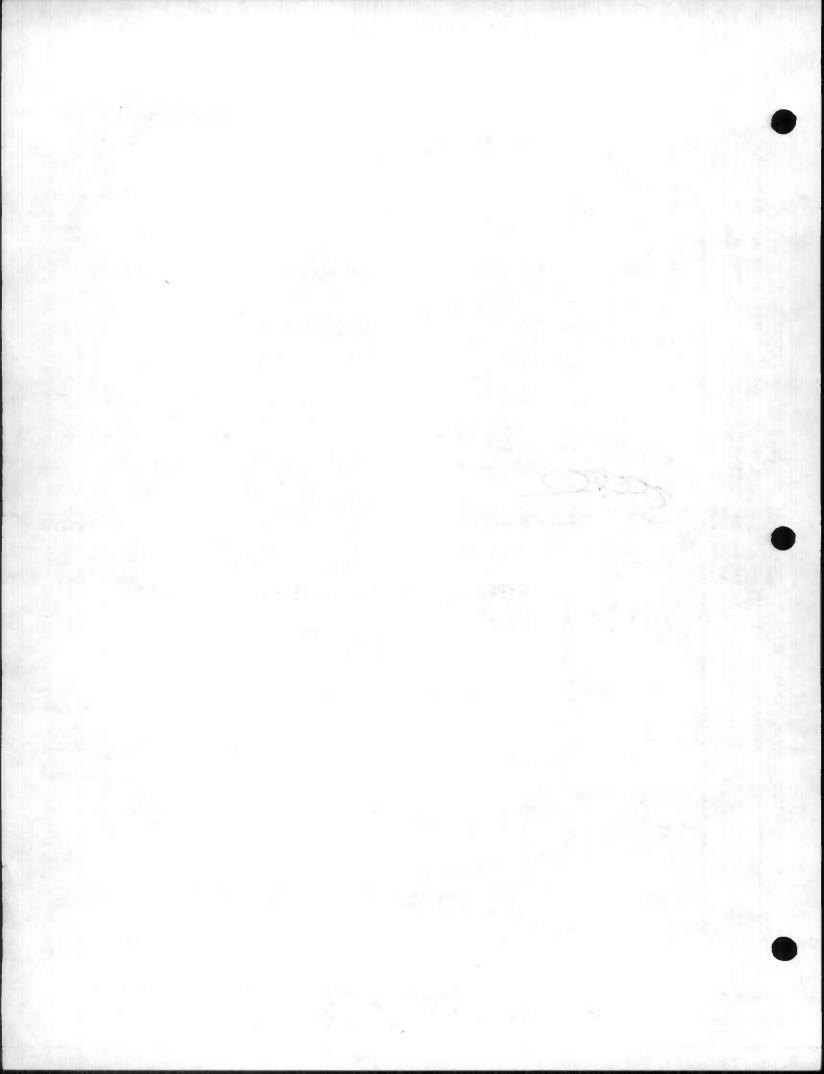
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BOON P. LIM M.D., 7601 OSLER DRIVE. TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year)

State Registrar

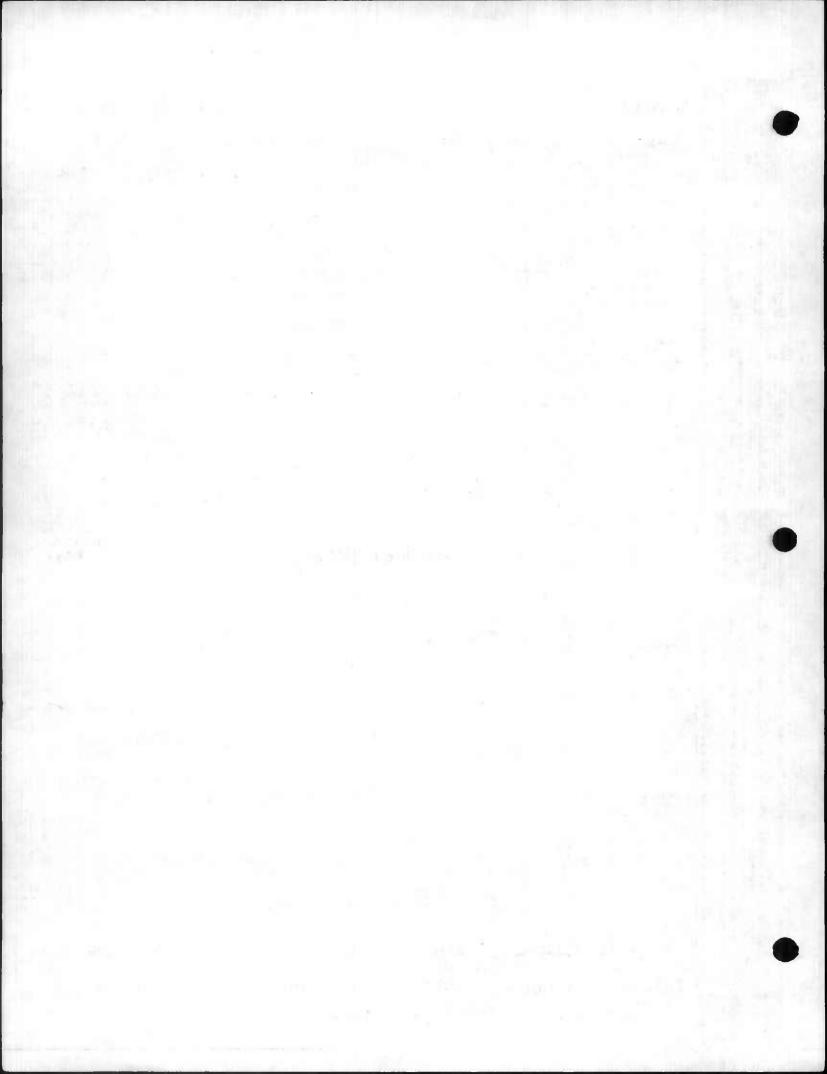
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State of Maryland / Department of Health and Mental Hygiene

			Certifica	e of Death	Re	eg. No.	08664
	Decedent's Name (First, Middle, Las	it)			2. Dete of Deat Month	h Day A Yea	3. Time of Death
Physician / Medical	VIOLET			SMITH	March		0 10:15 PM
Examiner 4a	Facility Name (If not institution, give	street and number)		300	n, or Location of Death	4c. County of D	eath
		3 HOSPITAL		BALTIM		/	V/A
rector 2	Social Security Number 6. S. 18-62-3367 1 sual Residence of Decedent	ex 7. Age (In yrs. I	S Yrs. Months	r 1 Year If Under 24 Days Hours	Min. 8. Dete of Birth (Month, Day,	Year) 9.1	Birthplace (State or Foreign Country)
10	e. State 10b. County	10c. City	, Town or Location	ALTIMO	PE CIT		10d. Inside City Limits 1
Director	e. Street and Number	A	101. Zi			Og. Citizen of What	Country?
# E _	1824 NORTH	DALLASSI	REET	2/6	231	US	
Funeral	. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U,	S. 13. Was Dece	dent of Hispanic Origin cify Cuban, Mexican, I	n? (Specify Yes or No- Puerto Rican, etc.)	14. Hace - A Bleck, W	merican Indien, /hite, etc.
۵	3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:	1□ Yes	2 No Specify:		Specify:	BLACK
e e	15. Decedent's Ed (Specify only highest gra		16a. Decedent's Usu (Give kind of wo	el Occupation ork done during most o se retired)	f working	16b. Kind of Busine	ss/Industry
B Complete	Elementary/Secondary (0-12) 4 + HGRADE	College (1-4or 5+)		se retired) PLOVED		N.	A
17.	. Father's Name (First, Middle, Last)	~		78. Mother's	Neme (First, Middle, M	laiden Sumeme)	
8 6	JOE	EDU	DARD	MAG	GIE	CAL	LAHAM
19	e. Informant's Name/Reletionship (1	ype, Print)		_	or Rural Route Number,		
OL 19	ORA SMITH	(DAUGHTER)	24/3 E	ASTEA			MD. 2/205
8	a. Method of Disposition 1 ■ Burial 2 □ Cremetion 3 □	Removel from State	emetery, cremetory or			Oc. Location - City	or Iown, Steta
Amfu 21	4 □ Donation 5 □ Other (Specify	1.6	T. ZON	EMETER	103-17-00 /	ANSDOU	WE, HARYLAND
Anful kue	. Signature of Eugeral Service Licen	Vallia	22. Name at	EPH H.	BROWN	TR. FUN	MD. 21217
23	Ba. Part1. Enter the disease, or comp shock, or heart leiture. List only	dications thet caused the death	. Do not enter the mod	le of dying, such es ca	ardiac or respiratory arre	st,	Approximete Intervel Between
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dis	mediete Cause (Final sease or condition	. Gastroin	testinal F	lee dins			0041
100	sulting in death)		as e consequence of)	0			
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Adical Examination that the second se	equentially list conditions, any, leading to immediate use. Enter Underlying buse (Disease or injury	Due to (or	es a consequence of):				
Ca Ca	nuse. Enter Underlying nuse (Disease or injury at initiated events	c					i
D res	sulting in death) Last	d.	as a consequence of):				
Physician/	rt II. Other significant conditions co		lting in the underlying	rausa sikon in Part I	23h Did to	hacco use contrib	ute to the cause of death?
			na garaga	growth to the			Probably 4 Unknown
A					24a. Wes er	eutopsy 24	lb. Were autopsy lindings
Completed					perform	ied?	aveilable prior to completion of cause of death?
Comp					1 N	s 201H6	1 ☐ Yes 2 ☐ No
a 25.	. Wes case referred to medical			26 Piece o	f Deeth (Check only one		10 163 2010
0	axaminer?	Hospital:	ER/Outpatient 3 Do	Other	ing Home 5 ☐ Reside		Specify)
cation: To	Manner of Death	1		28c. Injury at Work?	28d. Describe ho		poorty
offe	1 Natural 5 Pending 2 Accident investigation		Injury M	1 ☐ Yes 2 ☐ No			
	3 Suicide 6 Could not be determined	28e. Placa of Injury - At hor building, etc. (Specify,	me, lerm, street, lector	y, office	28f. Location (Str City or Town		Rural Route Number,
odical control	a. Certifier (Check only 2 Medical Exam	rsician: To the best of my know iner: On the basis of examineti	viedge, death occurred	at the time, date end p	place, and due to the ca	use(s) and manne	r as stated.
-	ane)	and manner steled.					
3 - 298	b. Signature and title of certifier	11		C. License number		9d. Date signed (Mi	
	JU SOUMA			RES-000	M	ARCh e	ighth 2000
30.	Name and address of person who o	ompleted cause of death (Item	23a) (Type, Print)	1.16. 01	+ Baltimer	0 110	
C/	Date filed (Month, Day, Year)	HANI GOI NO 32. Régistrar's Signet		INE Stree	T ISaltimo	c ray l	and
State State Registrar	MAR 1 5 200	10 Service	19. do	all			
				p.7			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dey 910 pm Yeer A. SMITH 09-BEVERLY 03-00 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death ROKEBY BALTIMORE NIA ROAD If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) 10M 20F Deys Months 14.64.7951 MO Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yea 2 No NIA BALTIMORE MP 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3905 ROAD ROKEBY 21229 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yea 2 ☐ No If Yes, Give Year or Datea: 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Marital Statua 1 Never Married 2 Merried 1 Yea 2 No Specify: Specify: BLACK 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) NURSE HEALTH CARE 4 YRS 12-TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) LEE ANDREW HOUD ERNESTINE WILSON 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOTHER 3905 ERNESTINE MCKNIGHT BALTO MO 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST 3.17.00 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MO. 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NATL PIKE, BALTO. Mp. 212; 21. Signeture of Funeral Service Licensee ams 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 200 No 3 Probably 4 Unknown 1 Ysa 24b. Were autopsy findings aveitable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 20 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 ☐ Other (Specify) 28b. Time of 28d. Describe how injury occurred

Examiner The law requires that the death certificate be executed use as the burial-fran and Box 68760 Division of Vital Records, P.O. page 2 should this certificate has or Attending Physician: After after death.

Director: Aft
d in by the ful completely filled in by

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Harris

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiens. ent. If Hem 27 is marked other than "natural", or its

8 Department of important if any injury or once.

Physician

/Medical

Physician/Medical Examiner

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Be Completed

Medical Certification: To

Baltimore, Maryland 21215-0020

must be notified

Funeral Director

by

Completed

25. Wes case referred to medical examiner? 1 Yes 28a. Dete of Injury (Month, Day Year) 27 Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 3 Suicide 28e. Place of tnjury - At home, term, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and plece, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date end plece, and due to the cause(s) and menner stated. 29e. Certifier

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type Print) Rollin Cou

29d. Date signed (Month, Day, Year)

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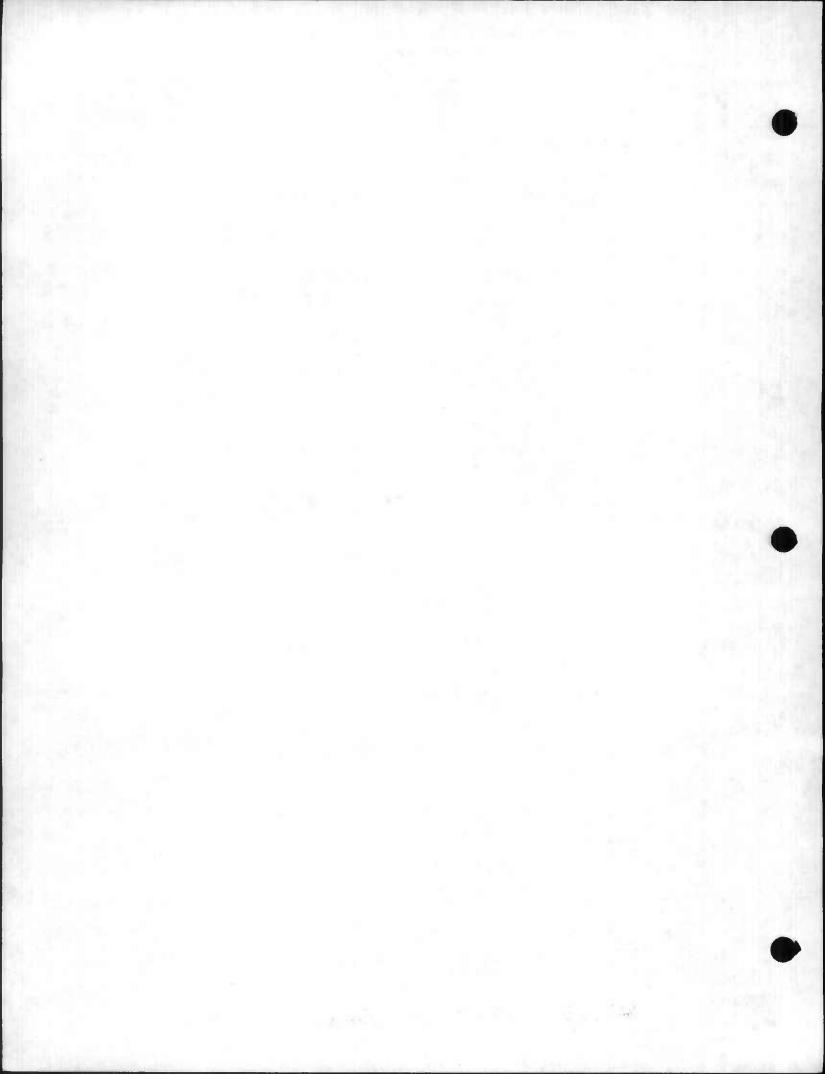
31. Date filed (Month, Day, Year) WAR 1 5 2000

29b. Signature and title of certifier

Degistra's Signature Special

29c. License number

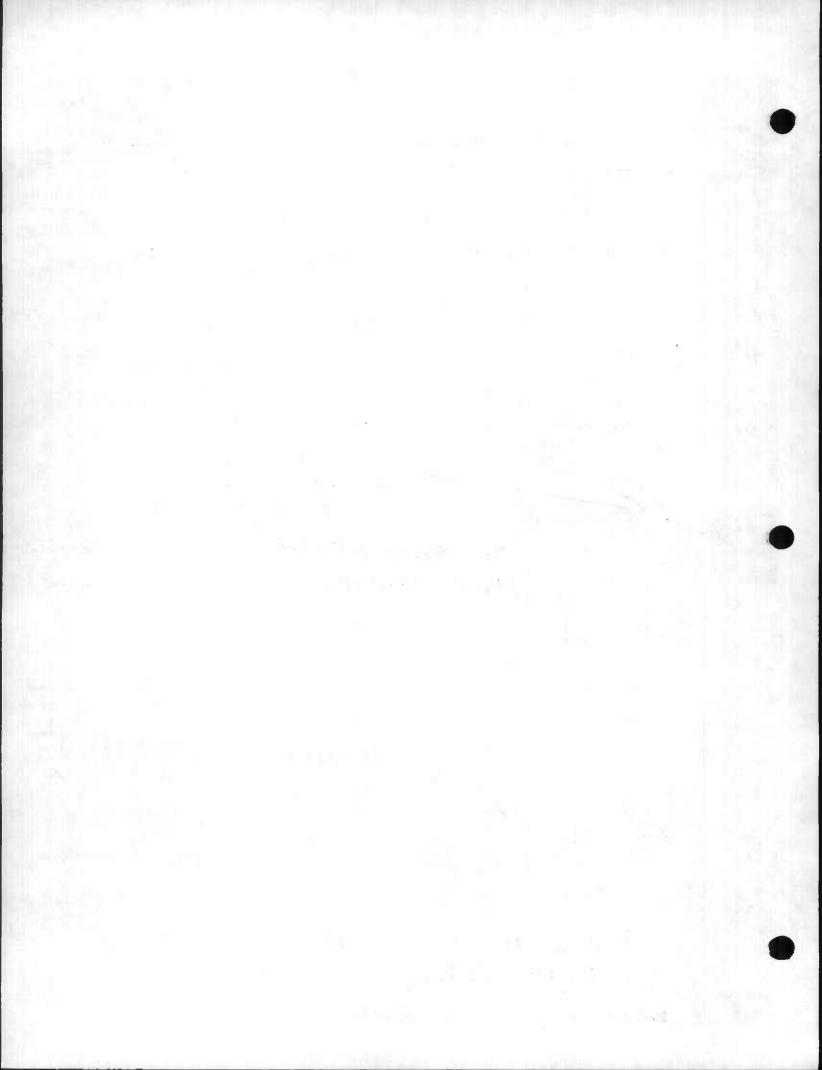
To the Hospital within 24 hours a To the Funeral D



_			(P** A 86' J.J. 1		aryları				Death		Reg. No.	I U	08666
п	Physician	1. Decedent's Name	(First, Middle, Last	,						2. Date of De Month	Day	Year	3. Time of Death
-3	/Medical		H. STROUS						D. Oh. Tour and	MARCH	10, 20		5:30 P.M.
	Examiner	4a Facility Name (II	not institution, give	street and number)					lb. City, Town, or L.	ocarion of Death	4c. County	of Death	
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	or 28s-f s be notified Director	10e. Street and Num	nber	ve unu s			10f. Zip	Code			10g. Citizen of V	Vhat Coun	try?
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5-0020	or the sample of Full	11. Manifel Status 1 □ Never Marrie 3 ₩ Widowed		12. Was Decedent Armed Forces? Yes 2 Hear Yes, Give Year or Dales:	No		Ves Dece Yes, spe		ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Specify	e - Americ k, White, o	etc.
21215-0	c 1 # -	(Special Elementery/Second 12TH GRA	15. Decedent's Edu fy only highest grad ndary (0-12)	cation le completed) College (1-4or :	5+)		kind of wo OO NOT u	rk doné d se retired	ation during most of work ()	king	16b. Kind of Bu		
	Hygiene. Afher then and, tree	17. Father's Neme (ELEC	CTRIC	LAIN	18. Mother's Nem	e (First, Middle,	UTILIT Maiden Sumam		MPANY
Maryland	d 2 should be filed within head Mentel Hygiene. 7 is marked other then traumetic event, the Menumetic event eve	LEVI ST	ROUSE						HELENE	SUMMER	ER		
ary	end Menis marke	19e. Informent's Na	me/Reletionship (T)	rpe, Print)		19b. Meilin	g Address	(Street	and Number or Rui	ral Route Numb	er, City or Town,	State, Zip	Code)
	C = N L	GREGORY	N. STROUS	E SON	1	206 1	BEECH	VIE	W CT. T	OWSON, I	MD 2128	36	
Baltimore,	80 4 5	20a. Method of Disp	osition Cremetion 3 DR	lemovel from State	20b. PI	ece of Dispos metery, crem	sition (Name	me of other plea	(0)	Dete	20c. Location -	City or To	wn, Slate
E	Pa Pa		5 ☐ Other (Specify)		DULA	NEY V	ALLEY	MEM	L GAR	3/14/200	OO COCK	EYSV	ILLE, MD
Sal	pemit. Pa Departmen Important: any injury	21. Signature of Fur	nerel Service Licens	96	_				ss of Facility ON FUNER				
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		thel initiated events resulting in death) L			Due to (or	es e consequ	uence of):				la di	1	
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Ä	e - 6 -									10	Yes 2 No	10	Yes 2000
ita	certificate rector, page Co	25. Was case referre	ed to medical						26. Place of Dee	th (Check only o	one)		
on of V	fer this ineral di on: To	1 Yes 221 27. Manner of Death 1 ZiNatural	40	lospital: 1 Inpatie 28a. Date of Inju (Month, De	iry	ER/Outpatien 28b. Time of Injury	-	28c. Injury World	4 LI Nursing Ho		dence 8 Oth	-	r)
Division	To the Hospital or Attending Profits 24 hours after death. To the Funeral Director: After tompletely lilled in by the funeral Medical Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inj building, et	ury - At hor c. (Specify	me, ferm, sire				28f. Location (: City or Tox		er or Rura	nl Route Number,
	To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier (Check only one)	1 Certifying Phys 2 Medical Examin	alcian: To the best nar: On the basis of and menner ste	examinati	rledge, deeth on end/or inv	occurred estigation	et the tim , in my o	ne, date and place, pinion, deeth occur	and due to the red at the time,	cause(s) end me date end place,	enner as si and due to	ated. the cause(s)
	To the common of	29b. Signeture and I	ille of pertifier Out Coun	~ MO			290		1452 1		29d. Date signed 3 - 1:	d (Month, 1 3 – OT	Day, Year)
2	7/1.	30. Nempland address	ss of person who po	D , PLN	eath Utem	23e) (Type, I	Print)M	D	2103	0			
	State Registrar	31. Dele tiled (Montt		Sansa A	er's Signat	lo lo	as No	,					

ORIGINAL

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

08667. Certificate of Death 2. Data of Death 1. Decedent's Nema (First, Middle, Last) 3. Time of Death Month Year **Physician** 12, MARCH VIRGINIA STEVENS 2000 10:00 PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 24 Hrs. If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 KF Yrs 86 Director Feb. 6 1914 Maryland 217-09-1563 Usual Residence of Decedent the Manyland t 0a. State 10b. County t Oc. City, Town or Location ahow 10d. Inside City Limits rithen "netural", or Herne 23e or 28e-f ahor The Medical Examiner must be notified at Director 1 ☐ Yes 2 X No MD Baltimore Timonium 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4 Kilglass Ct. #101 21093 LISA death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forcas? 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filled within 72 hours after to Department of Health and Mental Hygiene. Important: If frem 27 is marked other than "natural", or han page injury or other traumatic event, the page 1. Black, White, etc. 1 ☐ Yes 2 ☑ No Il Yes, Give 1 Nevar Married 2 Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: by 3 Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Keen Little Carrie Virginia Catterton 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t9e. Informent's Neme/Reletionship (Type, Print) Priscilla Lynn Stevens/ Daughter 4 Kilglass Ct. #101 Timonium, Md. 21093 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20e. Mathod ol Disposition 20c. Location - City or Town, Stete 1

■ Burial 2

□ Cremation 3

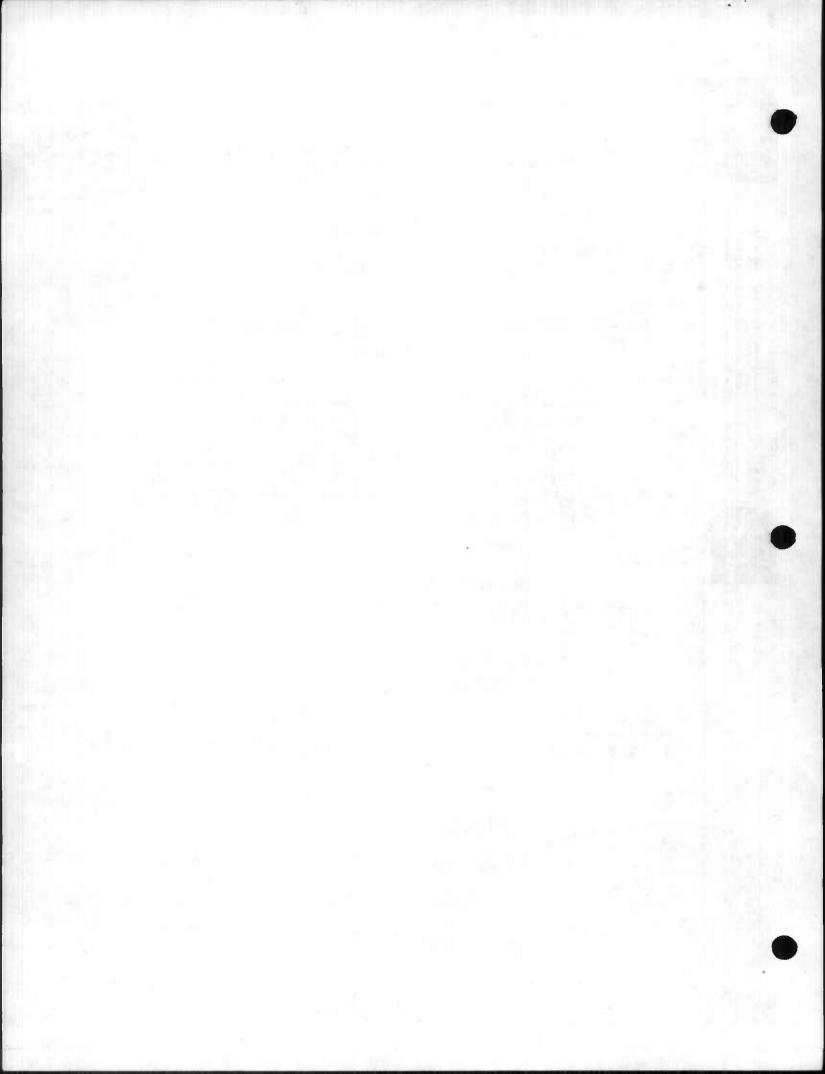
□ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Garrison Forest VA Cemetery 3-16-00 | Garrison, MD. 21. Signeture of Funerel Service Ligarum 22. Name and Address of Facility RUCK TOWSON FUNETAL Home, Inc. 1050 York Rd. Towson, MD. 21204 23a. Pertt. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart fellure. List only one cause on each line. Approximete Interval Betw Onset and Death **Physician** /Medical Immediete Ceuse (Final SEPSIS disaesa or condition rasulting in death) Examine Due to (or es e consequence of): Examiner NEUTROPENIA physician and the burial-transit that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 No 3 Probably 4 Unknown METASTATIC BREAST CANCER Division of Vital Records. p law requires been si 24a. Was an autopsy performed? 24b. Were autopsy lindings available prior to Completed completion of cause of death? page 2 PH-1 Yes 2 No 1 ☐ Yes 2 ☑ No or Attending Physician: 25. Wes case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: 1 I Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation death. t □ Yes 2 □ No 2 Accident after death Director: 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, lerm, street, fectory, office building, etc. (Specify) 4 Homicide filled in 24 hours a Hospital t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted. 29a. Certifier Medical To the Hosp within 24 hos To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifie D30263 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 FRANCIS KHOO M.M., 31. Dete liled (Month, Dey, Year) 32. Registrer's Signeture State Mener

Registrar

DHMH 16 Ray 6/95

MAR 1 5 2000



										0.	Death			Reg.	NO.			
	1. Dec	edent's Name	e (First, Midd	de, Last)									2. Data of D				3. Ti	na of Death
/sician	Jo	hn Howa	ard Th	omps	son								Month		Day 2	Year 2000	9:	25 AM
ledical aminer	4a Fa	cility Name (If	not institution	on, give s	street and n	number)					4b. City, To	own, or L	ocation of Dea	- 1	4c. County			
aiiiiiei	71	9 Maid	en Cho	ice	Lane	BRT07	,				Cator	ารงาร์	110		Ra1	timo	200	
		lal Security No		6. Sex				t birthday)	If Under	1 Year	If Under		B. Date of B	tirth	пал			tate or Foreign
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Funeral	11. Ma	arital Status			12. Was De Armed I	scedent Eve Forces?	r in U,S.	13. W	Yes, spec	ent of H ify Cubi	lispanic Or an, Mexical	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	No-		e - Ameri ck, White		ın,
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State Registrar 31. Date filed (Month, Day, Year) MAR 1 5 2000

29b. Signature and title of certified

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DERNARD F KOZLOVSKY, ND, 7/1 MA

7/1 MAIDEN CHOICE LANE, BALTINORE, MD 2/228

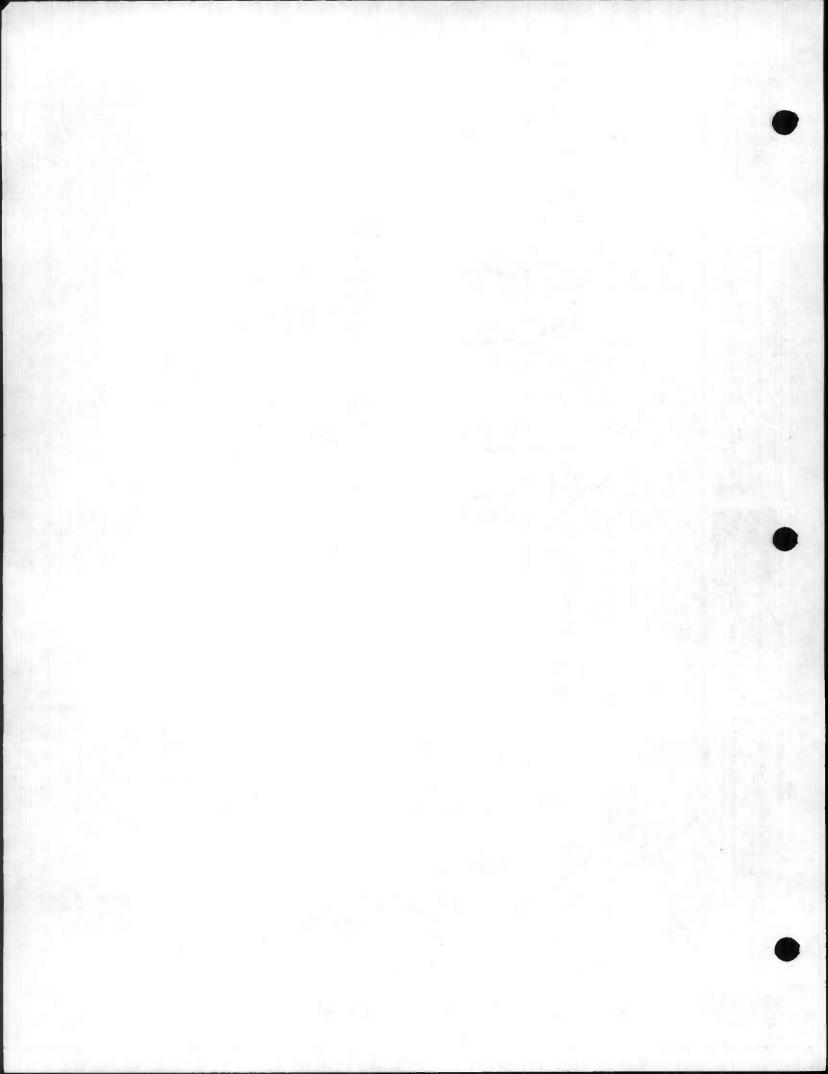
29c. License number

D26473

29d. Date signed (Month, Day, Year)

15, 2000

MARCH



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death

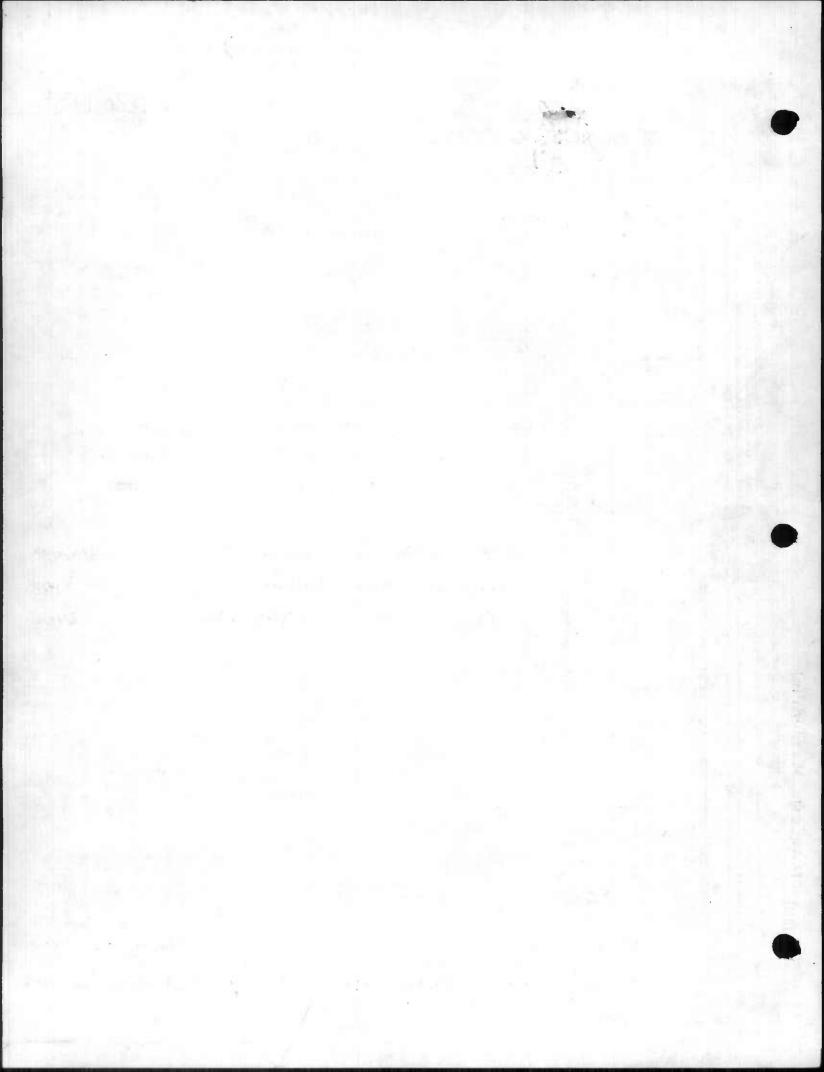
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sician	Marlen Maria T	urpin			March	n G	COOD	1955			
/Medical xaminer	4a Facility Neme (If not institution, give street and number)		4	Ib. City, Town, or t		eth 4c. County of Deeth					
	ST. AGNES HOSPIT	AL	Index 4 Vans	If Under 24 Hrs.	TOKE		N/A				
ral or	5. Social Security Number 495-42-1433 G. Sex 1 M 2 F 7. Age 1 M 2 F 7. Age		Under 1 Yeer oths Days	Hours Min.	NOV 2	th. Year 1924	Germ	ace (Stete or Foreign IN) IANY			
		10c. City, Town or Locatio	n				10	d. Inside City Limits			
Funeral Director	Maryland Anne Arundel	Pa	sadena		80.0			1 ☐ Yes X☐ No			
al Dire	10e. Street and Number 7751 Middlegate Court	10	of. Zip Code	21122		10g. Citizen of V		try?			
Completed by Funeral Director	11. Meritel Stetus 1 □ Never Merried 2 □ Merried 1 □ Never Merried 3 □ Widowed 4 □ Divorced 12. Wes Decedent Every Armed Forces? 1 □ Yes 2 □ Neo H Yes, Give \(\Lambda\) Yeer or Detes:	ver in U,S. 13. Wes If Yes	Decedent of H , specify Cube (es 2 No	lispenic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	14. Rad Ble Specify	ce - America ck, White, e v: Wh				
eted	15. Decedent's Education (Specify only highest grade completed)	16e. Decedent's	Usuel Occup	etion during most of wor	king	16b. Kind of B	usiness/Ind	ustry			
ldmo	Elementary/Secondery (0-12) College (1-4or 5+	Homemak		1)		Orm	Homo				
	17. Father's Neme (First, Middle, Lest)	Homemak	CI	18. Mother's Nen	ne (First, Middle		Home				
To Be	George Juvan			Maqde	lania	Unk.					
	19a. Informent's Name/Relationship (Type, Print)	19b. Meiling Ad	Idress (Street	end Number or Ru	ral Route Numb	er, City or Town,	State, Zip	Code)			
	Debra Sue Mills/daughter 20e. Method of Disposition	7751 M	iddlega	ate Ct.	Pasader	a, MD 2	1122	um Photo			
	1 Buriel 2 Cremetion 3 Removel from Stete	cemetery, cremator	y or other plea								
	4 □ Donation 5 □ Other (Specify) 21 Signature of Fundral Service Licensile	Metro Crema			3/7/00	Balt	imore	, MD			
	21. Signature of Fundral Service Licenside 22. Name and Address of Facility Cremation Society of Maryland, Inc.										
	Thomas Gregor 23a. Pert1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line	he deeth. Do not enter the	9 Frede	erick Roa	or respiretory e	imore,	MD 21	Approximete			
	shock, or heert feilure. List only one ceuse on each line	0.					ide e	Onset and Deeth			
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							1				
lan/	d										
Physician/M	Part II. Other significant conditions contributing to death but	not resulting in the under	ying ceuse giv	en in Pert t.				the cause of death'			
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Completed by					24e. Was perfe	en eutopsy ormed?	sva cor	ere autopsy findings silable prior to appletion of cause			
ошо						Yes 25 No		death?]Yes 2□ No			
Be Co	25. Was case referred to medicel			26. Place of Dea			1	1 198 ZLI NO			
To B	examiner?	t 2 ER/Outpetient 3	□ DOA Oth	or:		idence 6 Oth	ner (Specify)			
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cath	2 Accident investigation	A	1 1 🗆	Yes 2 □ No	004 1	Change	hases C :	I Bauta Ali			
Certification:	4 Homicide	y - At home, ferm, street, ((Specify)	ectory, office			Street and Num wn, Stete)	per or Rura	i Houte Number,			
edical C	29e. Certifier (Check only one) 157 Certifying Physician: To the best of e and menner stele	examinetion end/or investig									
Me	29b. Signeture end title of certifier		29c. Licens	e number		29d. Dete signe	ed (Month, I	Dey, Year)			
	MOCIAS M.D.		D	13591		MARCH	1 0	6,2000			
	1.00			10011	4	1 4 11/01	1	0 / 200-			
	30. Name and address of person who completed cause of dec	eth (Item 23a) (Type, Print		133 11		1 4 1001		0 / 2000			

State Registrar

DHMH 16 Rev 6/95

32. Registrer's Signeture

er's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND ITEM: #18 PER F.H. G781 3-15-2000 WR. Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day Month **Physician** 2:00pm Vernolia * Thornton Mar. 13, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3908 Carliste Avive Baltimore If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Months Days Min 10 M REXF Hours Yrs. Director 219-38-3334 uat Residence of Decedent 58 M.D 04 10a. State the Marylan r 28a-t show 10h County 10c. City. Town or Location 10d. Inside City Limits 1 ¥ Yas 2 No Director Baltimore MD NA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? iner must be b U.S.A. Funeral 3908 Carlisle 21216 Ave 12. Was Decedent Ever in U,S. Armed Forcas?

1 ☐ Yas 2 ② No If Yes, Give Year or Datas: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 11. Marital Status 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0020 'natural', or 1 Yas 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Hygiene. other then "neturn ent, the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Med within Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 17. Fether's Nama (First, Middle, Last) Balto City Schools Teacher 6yrs + permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event, addis. 18. Mother's Name (First, Middle, Maiden Sumame) Be - IOLA SMITH John T. Jackson Jr. Tolo Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tolo Smith-Mother 3908 Carlisle Ave, Baltimore Md 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 3-18-2000 Baltimore Co., Md Woodlawn Cemetery 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Baltimore, Maryland 21215 WM.C. March F.H. 4300 Wabash Avenue Part1. Enter the disease, or complications that ceused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** /Medical Immediate Causa (Final - sophageal Cancel disease or condition resulting in death) Examiner Dua (or as a consequence of): Examiner certificate be executed physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of) 68760. Physician/Medical Due to (or as a consequence of): US0 85 Box signed by the a P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Š or Attending Physician: The law requires 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yas 2 No 1 Yas 2 No Division of Vital 25. Was cese referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA To Other: 4 Nursing Homa 5 AResidence 8 Othar (Specify) 1 Yes 2 No this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1. Natural 5 Pending invastigation after death.
I Director: After the further 1 Yas 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital of within 24 hours of To the Funeral Di compietaly filled la 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and titla of certifier 29c. License number Kes-0001

State Registrar

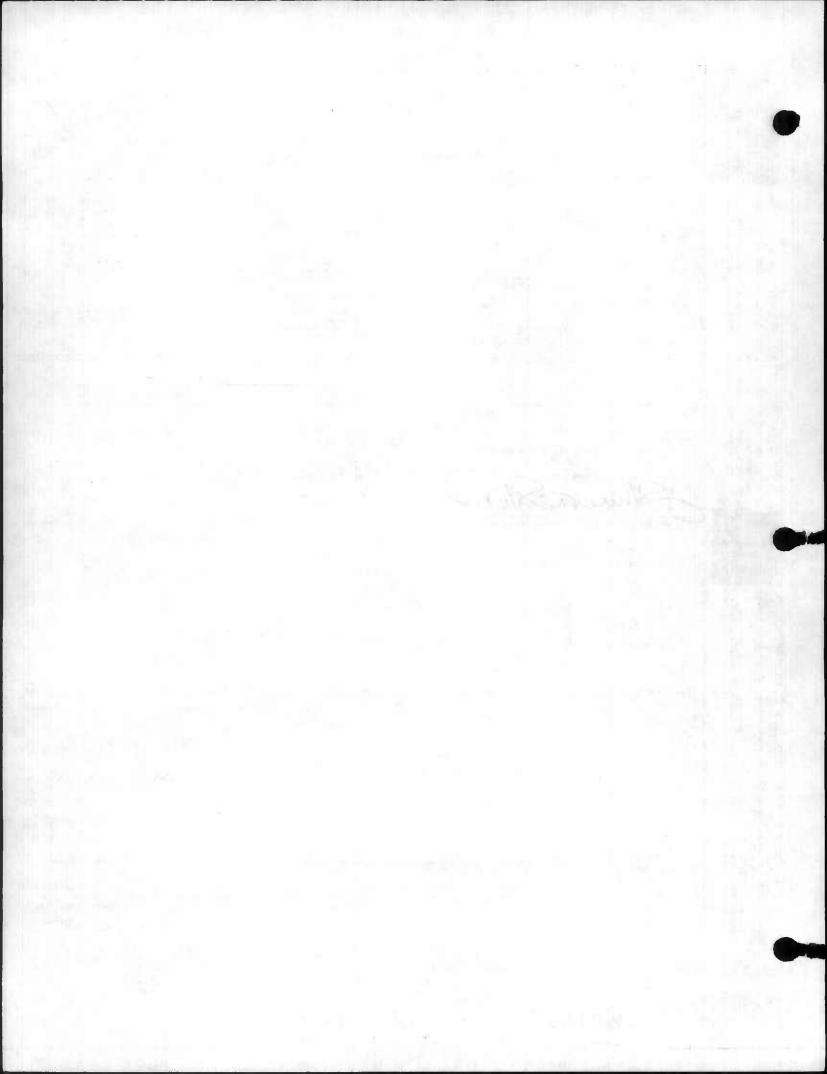
MAR 1 5 2000

Charles G. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)



Diake M.D. IPh.D. 600 N. Wolfe St. B. Himm, MO 21257



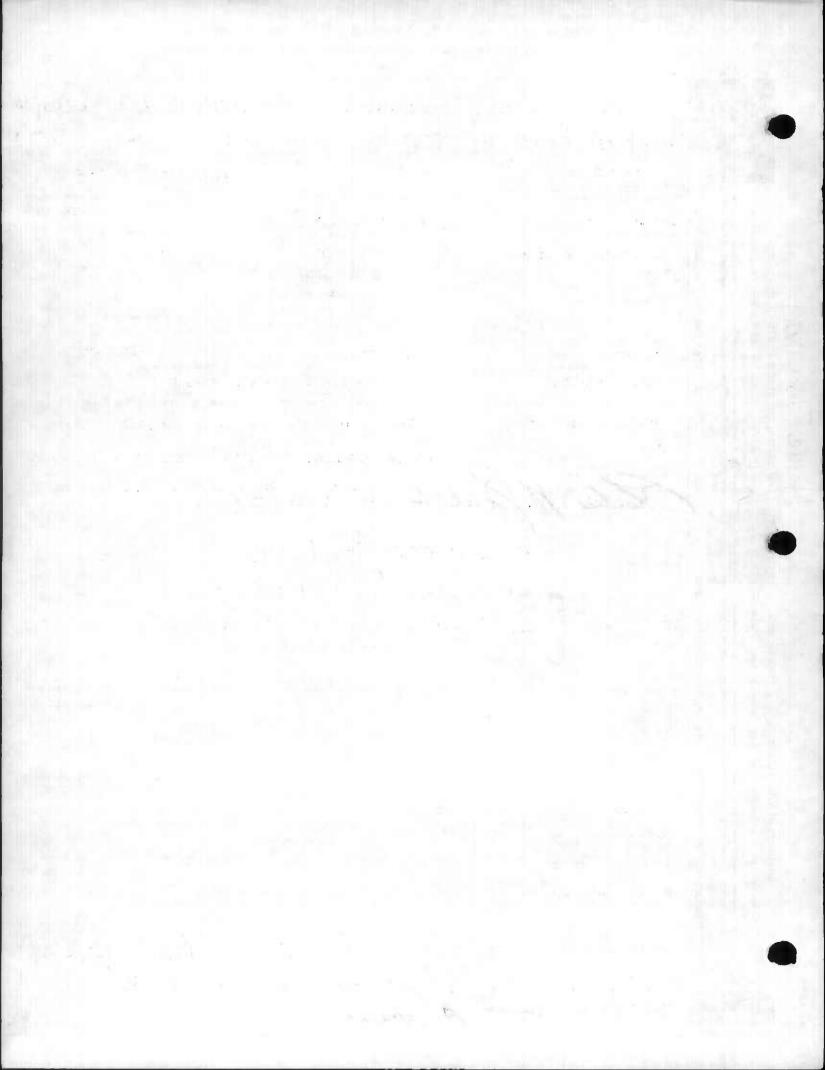
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedent's Nema (First, Middla, Last) 2. Date of Death **Physician** 000 1arch MARIE LOUISE TAYLOR-JOHNSON /Medical 4a Facility Nema (If not institution give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner ltimore 5. Social Security 7. Aga (In yrs. last birthday) Birthplece (Stata or Foreign Country) **Funeral** 1 M 2 X K Months Daya Hours 41 Yrs. Director 219-74-1349 JAN 23 1959 MARYLAND Usual Rasidence of Decedent 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limita 1 Xes 2 No Director MARYLAND N/A BALTIMORE CITY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be a 2300 McCulloh Street 21217 U.S.A. Funeral 12. Was Decedant Evar in U,S. Armad Forcas? 13. Wes Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14 Race - Amarican Indian Black, Whita, atc. 1 ☐ Yas 2 ☒ No If Yas, Giva Yaar or Datas: 1 □ Nevar Married 2 □ Married 1 ☐ Yas 2 ☒ № Specify: Specify: by 3 XXVidowed 4 ☐ Divorced BLACK "natural". Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) 94 HEALTH CARE 9th grade DOMESTIC 18. Mothar's Neme (First, Middle, Melden Sumama) 17. Fathar's Nama (First, Middla, Last) 98 ad bluoda JOHN H. TAYLOR BERNICE HAWKINS 19a. Informant's Name/Ralationship (Type, Pnnt) 19b. Mailing Addrass (Straat end Number or Rural Routa Number, City or Town, Stete, Zip Code) mportant: If Item 27 ny injury or other tr Diane Taylor/Sister 2300 McCulloh St., Baltimore, Maryland 21217 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data Pages 8 tXXBurial 2 ☐ Cramation 3 ☐ Ramoval from Stata OAK LAWN CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 3-18-00 BALTIMORE, MARYLAND 21. Signature of Funeral Sarvice Licensea 22. Nema and Addrass of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 75. Pert1. Entar tha disaasa, or complica shock, or haart failura. List only one 1206 W NORTH AVENUE cations that caused tha death. Do not antar the mode of dying, such as cardiec or respiretory arrest, excess on each line. Intarval Between Onset and Death Physician /Medical Immediata Cause (Final disaeae or condition resulting in death) Examiner nce of) Examiner physician end the buriel-transit the death certificate be executed Sequantially list conditions, if any, laading to immediate causa. Enter Underlying Cause (Disaasa or injury that initiated evants rasulting in deeth) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ania Physician/Medical attending | signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No by 24b. Wara autopsy findings aveilable prior to completion of ceuse of death? should 24e. Was en autopsy performed? Completed his certificate has b 2 NO 1 ☐ Yes 2 ☐ No Attending Physician: 25. Wes cesa referred in medical axaminar? Be 26. Place of Daath (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidance 6 Other (Specify) 1 Dinpatiant 2 1 Yes 257 No 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) Certification: 28d. Dascribe how Injury occurred 28b. Tima of 28c. Injury at Work? After 1 ONaturel 5 Pending death. 1 Yas 2 No invastigation 2 Accident after death Director: / 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28a. Place of Injury - At homa, farm, atreet, factory, office building, etc. (Spacify) 4 - Homicida 0 24 hours at Euneral D letely filled i 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, deta and place, and dua to the causa(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mennar stated. To the Vithin 2 To the Complet 29b. Signatura and titia of certifian 29c. License number 29d. Data signed (Month, Day, Year) Soumar

leme and eddrass of person who completed cause of daeth (Ifem 23a) (Type, Print)

32. Ragistrar's 5

MAR 1 5 2000

State Registrar



			EMS: #23 PART I			0.05	301			Death		2. Date of D		Ve	3. Time of Death	
	hysicia: /Medica		Judy Eller	Wilk	cins							March	09, 200	OYear	8:41 A.M	
200	xamine		la Facility Name (If not institution									ocation of Dea				
			#5 St. Timothy	's Lan	е							rille	Ba	altim	ore	
	neral ector		108-30-7457	6. Sex 1 □ M 20	7. Age	(In yrs. la	st birthday) Yrs.	Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of B (Month, D MAR	irth Nay. Year) L5, 1941	9. Birth Cou Nev	placa (Stele or Foreig intry) V York	
Pug	E	-	Usual Residence of Decedent 10a. State 10b. County			10c. City,	Town or Loc	cation					10d. Inside City Limits			
Mary	lad at	ō	MD Bal	timor	imore Catonsville			2						1 ☐ Yes 2 🕍 No		
-	d be notified at	Direc	10e. Street and Number 5 St. Timothy	's La	ne			10f. Zip Code 21228				10g. Citizen of USA	What Cou	intry?		
# ·			11. Marital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was	s Decedent Ened Forces? Yes 2 \times Nes, Give			Vas Dece Yes, spe				ecify Yes or N Rican, etc.)		ce - Amer ack, White		
72 hours of			15. Decedent		if or Detes:		16s Deced	ant's Hen	al Occur	nation	_		16b. Kind of I	Business/l	ndustry	
			(Specify only highes	t grade compl	de completed)		16a. Decedent's Usual ((Give kind of work life. DO NOT use		rk done se retire	during mos d)	t of work	ing	Phys			
d within glene.		E	Elementary/Secondary (0-12)		College (1-4or 5+) 5+		High School						Educa			
			17. Father's Name (First, Middle, I	.ast)									e, Maiden Suma	me)		
Mental										ne Lawr	ence	e				
			19a. Informent's Neme/Reletionship (Type, Print) Kathleen G. Woodams/sister 19b. Meiling Address (Street and Number or Flural Route Number, City or Town, Stete, Timothy's Ln., Catonsville													
. 53			Kathleen G. V	Voodam	ns/sis						Ln	., Ca	_			
o o	8	1	20a. Method of Disposition 1 ☐ Buriat 2/☐ Cremetion	3 □Removel	emovel from State 20b. Place of Disposition (Name of cemetery, cremetory or other place)											
Pac	r v		4 Donation 5 Other (Sp		THOM State	Met	cro Cr	emate	ory,	Inc.	03/	15/00	Baltin	nore	, MD	
permit. Pages 1 Department of He	any Injury o		21. Signature of Funeral Service of Edward A								Maryla Ltimore					
			23a. Pert1. Enter the discount, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.								errest.		Approximete Interval Between			
Phys	_		U												Onset and Deeth	
	dical niner		Immediate Cause (Finet disease or condition		ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE											
No. of the			resulting in death)		Due to (or as e consequence of):											
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Micata be a		DO CO	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of the												7 - 4 -	
ath cent		a L		d										1		
net the d	gned by the atterbe detached for u		Part II. Other significant condition	ns contributing	g to death bu	t not result	ting in the un	derlying o	ause gi	ven in Pert I	1.		tobecco use c		to the cause of death	
requir						T _i					100	24a. Wa per	s an autopsy formed?	a	Vere autopsy findings vailable prior to ompletion of cause	
ě	pege 2	Compieted								of death			16			
Physician: T	director, pag	9	25. Was case referred to medical examiner?	Manadak					low		of Deel	th (Check only	one)			
hy i		2	1(X)Yes 2□ No	Hospital:	1 ☐ Inpatier Date of Injun (Month, Day)		R/Outpatient		JA		ursing Ho		sidence 6 0		eify)	
	funeral	5 6	27. Manner of Death 1) □ Natural 5 □ Pending	28b. Time of Injury		28c. Inju Wo		No	28d. Describe	how injury occi	Irred					
ttendi death.	In by the	Certifications	2 Accident 3 Suicide 4 Homicide Accident Investigation M							1 ☐ Yes 2 ☐ No office 28f. Location (Street and Number or Rural Route Number City or Town, State)				ral Route Number,		
Hospital or Attending A hours after death.	npletaly filled in	5 1														

29c. License number O.C.M.E. 29d. Date signed (Month, Dey, Year)

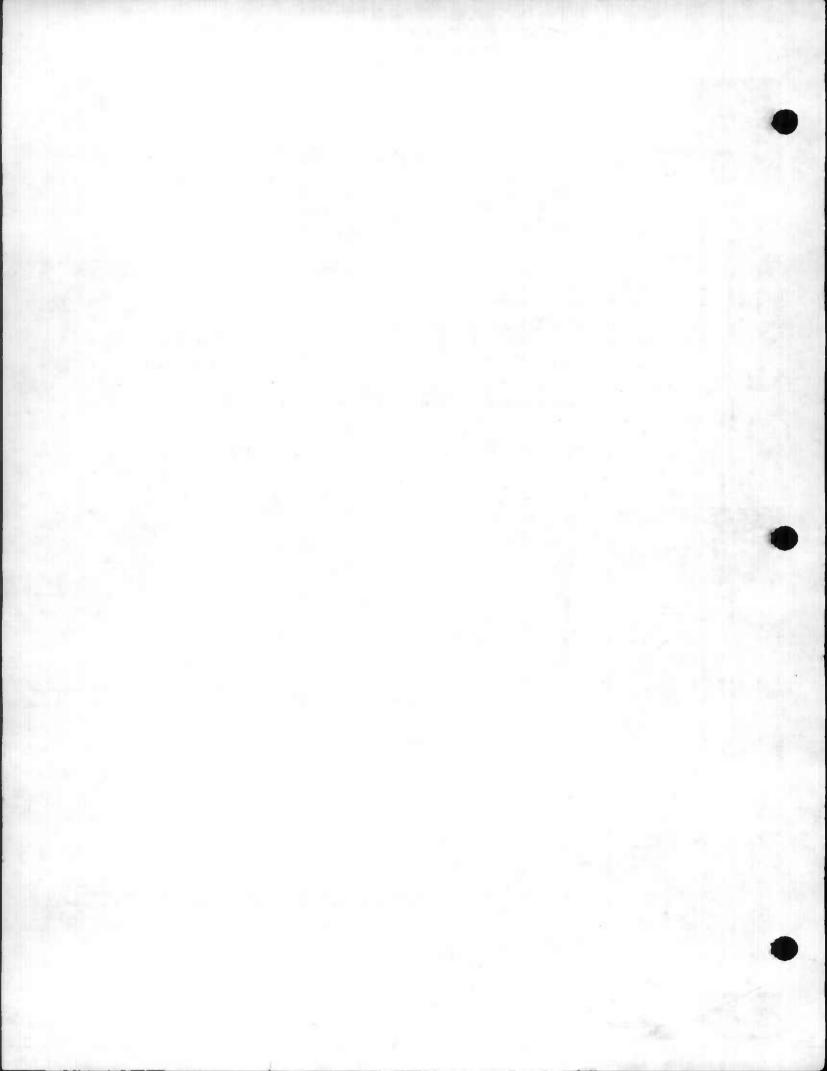
March 10, 2000

and address of person who completed cause of death (Item 23a) (Type, Print) MO WOKE

2000 32. Registrar's Signature

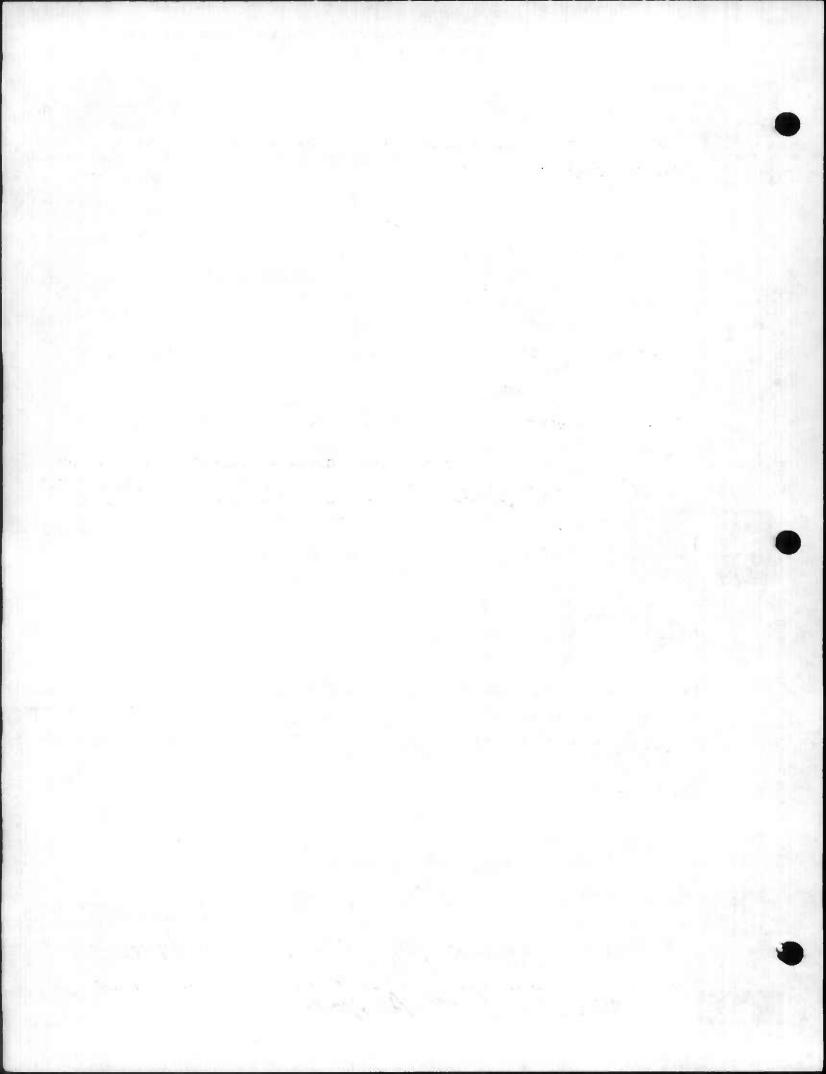
111 Penn Street, Baltimore, Maryland 21201

State Registrar



State of Maryland / Department of Health and Mental Hygiene 10 08672

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/Medical	ı la	Vames 1	URIGHT					3.	9 -	00	8:45 pm
xaminer	1	4e. Fecility Nama (If not Institution, give					4b. City, Town, o	r Location of Dee	th 4c. Coun	ty of Deeth	1
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Oirec		10e. Street end Number				10f. Zip Cod	a		10g. Citizen of	What Country	7
Examiner must be by Funeral Di	3	1152 E. North	ern Park	way		212	239		USA		
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cal	1	23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediata Causa (Final diseasa or condition	plications that cause of each	ed the death.	Do not and	tar tha moda of	,	ac or raspiretory	arrast,	Ap	U E proximete ervel Between nsef end Death
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legibie. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Year Month Physician MAR Govan WORREIL 12:50 AM 2000 11 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospital Baltimore St. AGnes none If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Mgnth, Day, Year) 9. Birthplace (Stata or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2□ F 224-34-6734 70 Yrs. Oct. 27, 1929 VIRGINIO Director Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow BAHIMORE 12 Yas 2 No Directo none HARYland 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? ò 3401 Woodband 238 21215 USA Ave Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) or items 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Never Married 2 Married aitimore. Marviand 21215-0020 1 ☐ Yas 2 No Specify: 2 3 ☐ Widowed 4 ☑ Divorced AMERICAN 'natural', 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Mechanic Self permit. Pages 1 and 2 should be filled will Department of Health and Mental Hygiens Important: If item 27 ie marked other twarty Injury or other treumatic event, that place. 1046 Auto none 17. Father's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Maiden Surnama) Be Elizabeth Barnes 2 Govan WORRELL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 3401 Woodland Ave. Baltimore, Maryland 21215 loe Milton DRREIL 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Burial 2 Cremation 3 Removal from State /2000 Ingleside MARYAN DESTERN StAn 4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Fecility Narby M. Wallace Funeral Service 3405 W. FRANKLIN Street-BAHIMORE, MARYland Welane 10515 23a. Part Terrer the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrast shock, or hear value. List only one cause on each line. Approximate Interval Batween Onsat and Death **Physician** /Medical Immediata Causa (Final =PSIS diseasa or condition rasulting in death) Examiner Dua to (or as a co Examiner DIVEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of) Box 68760 Physician/Medical Dua to (or as a consequence of): 980 Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? o 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Concer Records, 2 24b. Wera autopsy findings available prior to complation of cause of death? 24a. Was en eutopsy performed? Completed 1 Tas 2 00 No 1 ☐ Yes 20 No Vitai Be 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yas 2 No 1 Inpatient 2 ER/Outpatient 3 DOA of this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Attending 1 Naturel 5 Pending invastigation Division 1 ☐ Yas 2 ☐ No death. 2 Accident Director: n 24 hours after des Ne Funeral Director nistaly filled in by th 3 Suicide 6 Could not be 261. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicide 6 edical 29a. Certifie 1 Certifying Physician: To tha best of my knowledge, death occurred at tha time, data and place, and due to tha causa(s) and mannar as stated. To the Hosp within 24 hos To the Fune completely fi 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. Licanse number Maulan March 11 2000 46704 30. Nama and eddrass of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL ACNOS CANKINDE 5

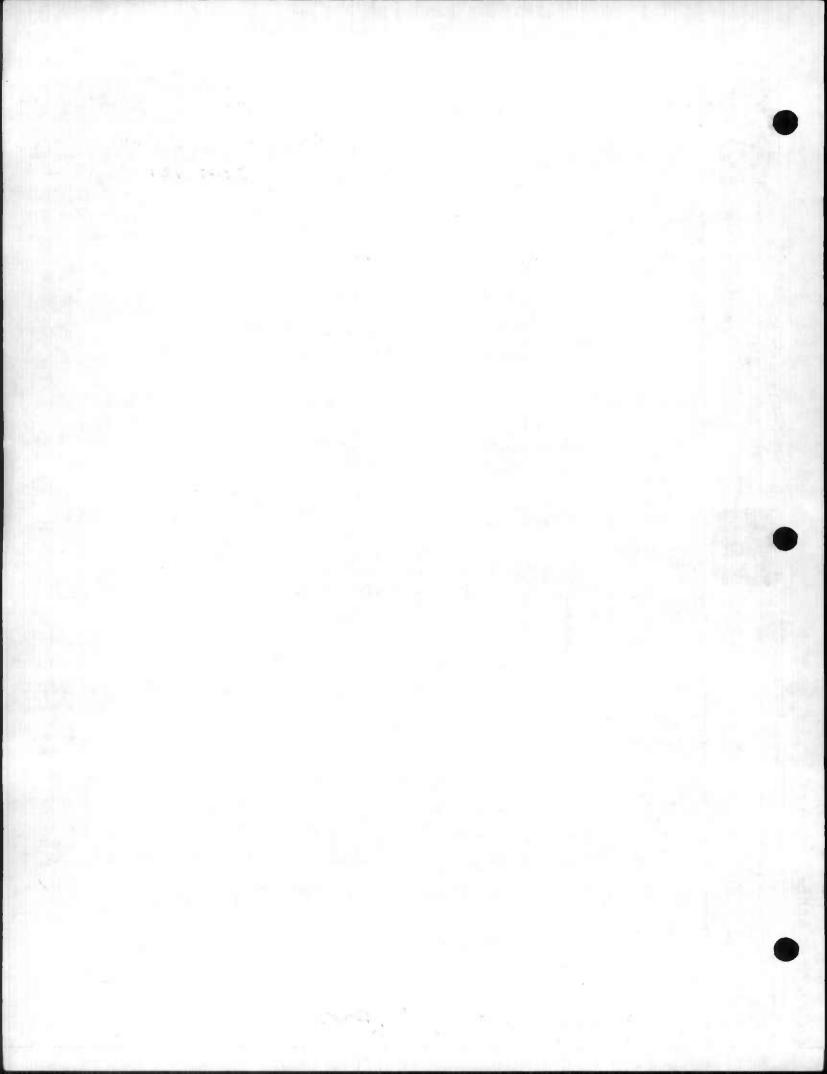
Registrar

MAR 1 5 2000 **DHMH 16 Rev 6/95**

31. Data filed (Month, Day, Year)

MUTOMBO

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Month Day WALKER MARCH 11, 2000 20:05 4b. City, Town, or Location of Death 4c. County of Death

Physician /Medical Examiner

Funeral Director

Director

by

the Maryland 7 is marked other than "natural", or items 23s or 28s-f show traumetic avent, the Medical Exemple man be notified all

death permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Intropramt: If Itam 27 is marked other than "natural", or item any injury or other traumatic avant, the Health and abota.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner Examiner physician and the bunal-tran Box 68760 the for use as P.O. signed by I Records, should Division of Vital or Attending Physician: Be Certification: To this after death. Director: Aft To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by th Medical

Physician/Medical þ Completed

Completed 29a. Certifier

1. Decedent's Neme (First, Middle, Last) DANIEL 4a Facility Neme (If not institution, give street and number) 3915 ROKEBY ROAD BALTIMORE N/A H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Ye Birthplace (State or Foreign Country) Months Days 219.16-9601 10 M 20 F VA Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location YETYes 2 No BALTIMORE N/A MD 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21229 3915 ROKEBY RD. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No If ¥es, Give Year or Dates: W W 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Black, White, etc. 1 Never Merried 2 Married Black 1 Yes 2 No Specify: Specify: WWI 3 Widowed 4 □ Divorced 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) FOOD/POULTRY TRUCK DRIVER 6 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Celia Walker UNK 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3917 ROKEBY RD. BALTO., MD. 21229 PATRICIA HARDY-AVENS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20e. Method of Disposition Date 1 ☐ Buriel 2 ☑ Cremetion 3 ☐ Removel from Stete 3/14/2000 Balto., Md. Crematory Metro 4 Denetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22 Name and Address of Facility & Sons F.H., Inc. mps (i 1701 Laurens St. Baltimore, Md. 21217 23a. Pelt 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Ceuse (Finel disease or condition resulting in deeth) Due to (or as e consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Disease or injury that Initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 5 Unknown 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) XYes 2□ No 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 2 ☐ Accident 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. (Check only one) and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatury

elsa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

MARCH 12, 2000

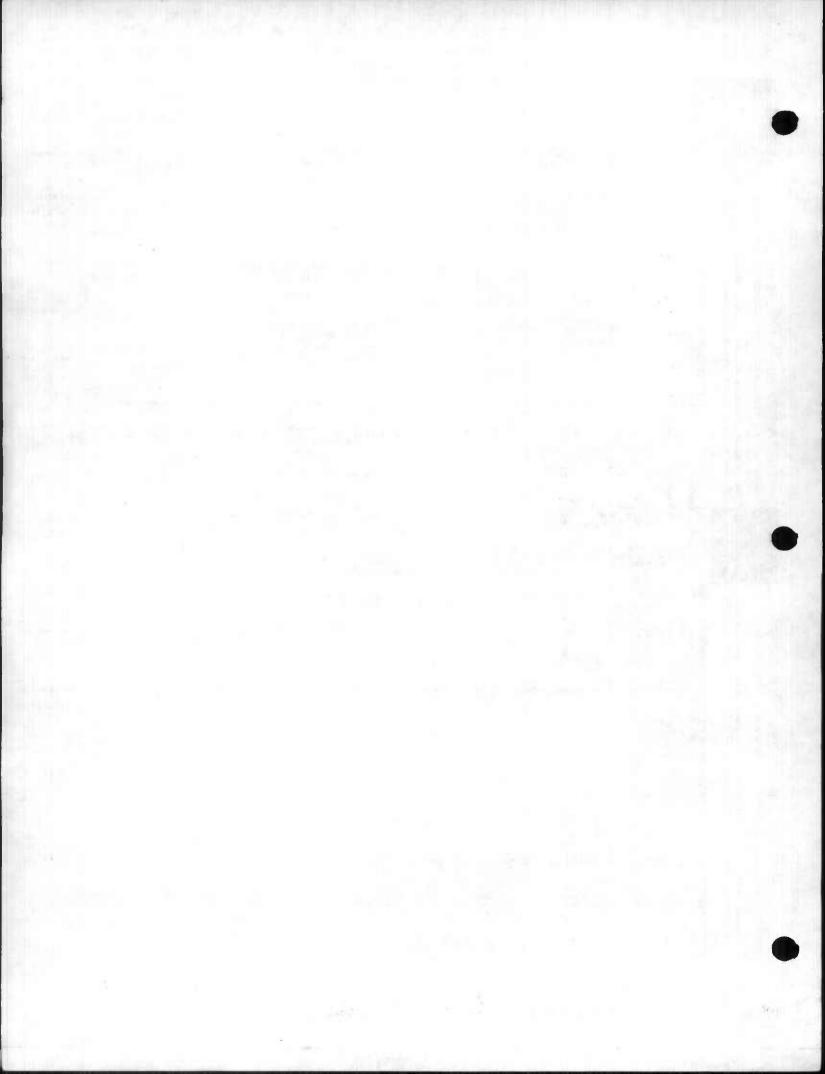
LeckE My 31. Date filed (Month, Day, Year) MAR 15 2000

32. Registrar's Signature

O.C.M.E.

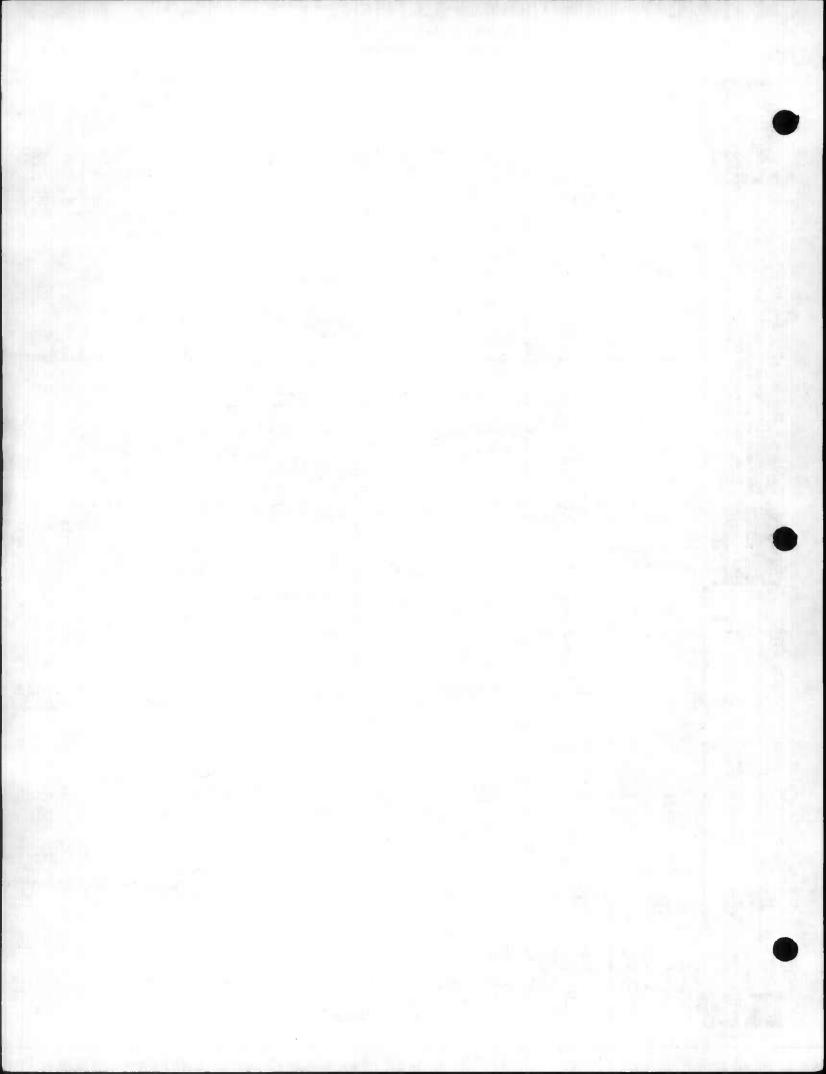
DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene 00 08676

				Certificate	of Death	Re	ig. No.	00070
	5 1	1. Decedent's Name (First, Middle, La	ist)	1		2. Dete of Death Month		3. Tima ol Death
	Physician /Medical	JEROME	ANTHONY	WILSON	SR.		Dey 2000	
	Examiner	4a Facility Name (If not institution, given			4b. City, Town, or	Location of Death	4c. County o	of Death
123		PRINCE GEORGE'S	HOSPITAL CENTER	2	CHEVERLY	Z	PRINC	CE GEORGE'S
	Funeral Director		Sex 7. Age (In yrs. 124 M 2□ F	16 Interest birthday) If Under 1 Months D	faar If Undar 24 Hrs Beys Hours Min		Year) 54	9. Birthplace (State or Foreign Country) MARYLAND
Pug	ž w	10a. State 10b. County	10c. City	y, Town or Location				10d. Inside City Limits
the Manyland	or 28e-f show be notified at Director	MARYLAND 10e. Street and Number	JIA	101, Zip Co	ALTIMO		7 TY	1 No les 2 No
death with	23e or	4708 GREE	NSPRING AVI	ENUE	2121	14	us	SA
5-0020 72 hours after de	al', or flams 234 Example ment by Funeral	3 ☐ Widowed 4 ☐ Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	If Yes, specify	t of Hispanic Origin? (S Cuben, Mexican, Puer No Specify:	to Rican, etc.)		- American Indian, k, White, etc.
5-0 72 ho	or the Medical Completed	15. Decedent's E (Specify only highest gri		16a. Decedent's Usuel O	occupation fone during most of wo	ndkina 1	16b. Kind of Bus	siness/Industry
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	CO The		ZYRS	PROJECT				CARNES ASSOCIATE
DI S	- 55	17. Father's Name (First, Middle, Last			n	me (First, Middle, M	laiden Sumame	1
y y	P P			TURNER	KOBE		J.	WILSON
Maryland	The man	19a. Informent's Name/Relationship (19b. Mailing Address (S				
- 5	= 64 -	MICHELLE WILSO 20a. Method of Disposition		3806 EA	NOR ROL	AD, BAL	TIMORE	MD. 21218 City or Town, State
Saltimore	5=5	1 Burial 2 Cremetion 3	Removel from State	emetery, crematory or othe	r piace)			
tim.	tant: h	4 Donation 5 Other (Special	y) GA	PRRISON FO	REST	03-17-00 0	WING	S MILLS, Mb.
Balt	mportant: any injury	21. Signature of Funeral Service Lieur	1566	22. Neme end A	ddress of Facility BA	20WN JK	2. FUN	ERAL HOME
- 0.0	2240	John Del	sums	21401	V. FULTON	JAVE. A	BALTIM	IORE, MO. 21217
	-	23a Parti. Enter the disease, or com shock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not enter the mode o	dying, such as cardie	c or respiretory arre	st,	Approximate Interval Between
	ysician							Onset and Death
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0 4	ed by the detached	Part II. Other significant conditions of	ontributing to death but not resu	uting in the underlying caus	e given in Pert I.			tributa to the cause of death?
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Records,	shoul ete					24e. Wes en		24b. Were autopsy findings available prior to completion of cause of death?
Rec he law	page 2 a	E-B-AUL AL					s 2 No	1 Ves 2□ No
-	certificate irector, pag	25. Was case referred to medical			00 51 15-	1 1 Ye		TEN THE ZEINO
Vita		examiner?	Hospital:	ER/Outpatient 3 DOA	Other	eth (Check only one		(0)
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On Ging	to the	1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day Year)	1240 M	Injury at Work? 1 D Yes 2 □ No	0.		Eines asserts
Division or Attending	al Director: After the funanted in by the funanted Certification:	3 ☐ Suicide 6 ☐ Could not b	e 200 Place of Injury At he	ome, lerm, street, lactory, of				or or Rural Route Number,
7	Pre de la company	4 Homicide	building, etc. (Specify	Soury		City or Town,	, State)	
a port		29a. Certifier 1☐ Certifying Ph	ysician: To the best of my know		he time, dete end plec			nor es stated.
To the Hospital	To the Funeral Directors. Mer th completely filled in by the funeral Medical Certification:		niner: On the basis of examinat and manner stated.	ion and/or investigation, in	my opinion, deeth occ	urred et the time, da	te end place, ar	nd due to the cause(s)
o th	Me (Me	29b. Signature and title of certifier	A	29c. Li	cense number	29	ld. Date signed	(Month, Day, Year)
	V	10410,70	helpile		O.C.M.E.		марси 1	13, 2000
	X	30. Name and address of person who	completed cause of death (Item	23a) (Type Print)	O.C.M.E.		rench !	.5, 2000
	0	40 My nows 1	S- Worker My		Street, Ba	ltimore.	Marylar	nd 21201
	State	31. Date filed (Manth-Pay, Year)	32. Registrar's Signal	luca e			7	
	Registrar	Mink 1 5 200	Depena	B. Span	Kal			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death WAHLBERG Month HILDA 6:00 pm MAR 00 12 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death HOWARD COUNT GENERAL HOWARD OLUMBIA HOSPITAL 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1 M 20 F 214-42-9238 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2X No HOWARD COLUMBTA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6400 BRIGHT PLUME 21044 U.S.A. 12. Wes Decedent Ever in U,S. Armed Forces? 11 Marital Status 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 ☐ Yes 2 No 1 Never Merried 2 Merried 1 Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) OWNER RETAIL 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) LOUIS ROTH **JENNIE** HARTMAN 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6400 BRIGHT PLUME - COLUMBIA, MD 21044 MELVYN WAHLBERG / SON 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removal from State 4 □ Donation 5 □ Other (Specify) BETH ISRAEL CEMETERY 3/14/00 SALISBURY, MD 22. Neme and Address of Facility SOL LEVINSON & BROS., INC. 21. Signeture of Funeral Service Licenses 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate tnterval Between Onset end Death CEREBRAL VASCULAR ACCIDENT Immediata Cause (Finel 3 DAYS disease or condition resulting in deeth) Due to (or es a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTIA 24a. Wes an eutopsy performed? 24b. Were eutopsy findings available prior to completion of cause of deeth? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MAR, 12,00

Box 68760. P.O. Records, Division of Vital this After

Examiner Physician/Medical Be Completed Medical Certification: To

Physician

/Medical

Examiner

Director

Funeral

4

Completed

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Funeral

Director

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Pages 1 and 2 should be fill ment of Health and Mental Hants If them 27 is marked off lury or other traumatic even

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

or Attending Physician: 24 hours after death. in by Hospital

within 2 5

> State Registrar

DHMH 16 Ray 6/95

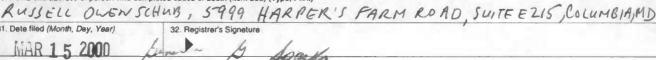
31. Dete filed (Month, Day, Year)

6 Could not be determined

3 Suicide

29a. Certifier (Check only one)

4 Homlcide



30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

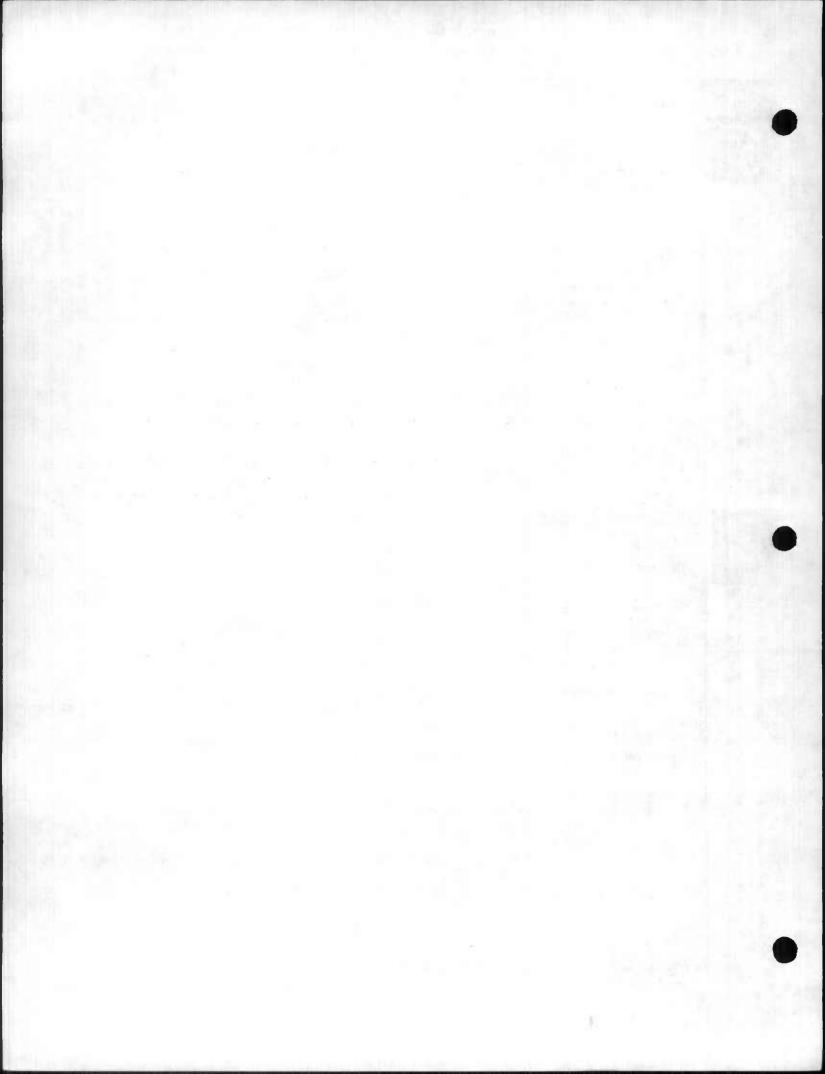
Specks

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

chur-physicien

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) end menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated.

29c. License number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Yeer **Physician** James David Wallace 2000 1:15 March 12 /Medical 4c. County of Death 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Square enter Baltimore Hospita tranklin osedale 8. Dete of Birth (Month, Day, Year) Oct. 16,1937 If Under 24 Hrs. If Under 1 Year 5. Social Security Number Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Deys Months 496-36-7950 12 M 2 F 62 Colorado Director Usuel Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. tnside City Limits Herns 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yas 2 ☐ No Director Maryland Baltimore Dundalk 10e. Street end Number 10g. Citizen of What Country? 10f. Zio Code 21224 United States 809 Old North Point Road Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 Å yes 2 □ No If Yes, Give Yeer or Detes: Vietnam 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 25 Married "natural", or 1 Yes 2™No Specify: Specify g 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Baltimore City Policeman Law Enforcement 2 Years 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Important: If item 27 is marked any injury or other traumatic av Marcella Stapp William E. Wallace 0 19a. Intorment's Neme/Relationship (Type, Print) (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 Old North Point Road Baltimore, MD 21224 Mrs. Gertrude L. Wallace 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removal trom State Hilltop Service Corp. 3/16/00 Towson, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Juneral Service Licensee 22. Name end Address of Fecility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the Oseese, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or hear palure. List only one cause on each line. Approximate tnterval Between Onset end Death Physician /Medical Immediate Ceuse (Final hagic disease or condition resulting in death) Examiner Examiner SIOF Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or es a consequenca of): Pert II. Other eignificant conditions contributing to deeth but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown p 24b. Were autopsy tindings available prior to Completed 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 20 No 1 Yes 2 No 25. Wes case reterred to medical exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. tnjury et Work? 1X Neturel 5 Pending 1 TYes 2 □ No investigetion 2 Accident 6 Could not be determined

and Box 68760 8 P.O. signed by the Records, Division of Vital After Attending death. hours after deat 6 within 24 hours aft To the Funeral Dis completely filled in

end Mental

within . 5 2 DXI

State Registrar

3 Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signeture and title of certifier

who completed cause of death (ttem 23a) (Type, Print)

28e. Place of Injury - At home, term, street, tectory, office building, etc. (Specify)

29d. Date signed (Month, Day, Year)

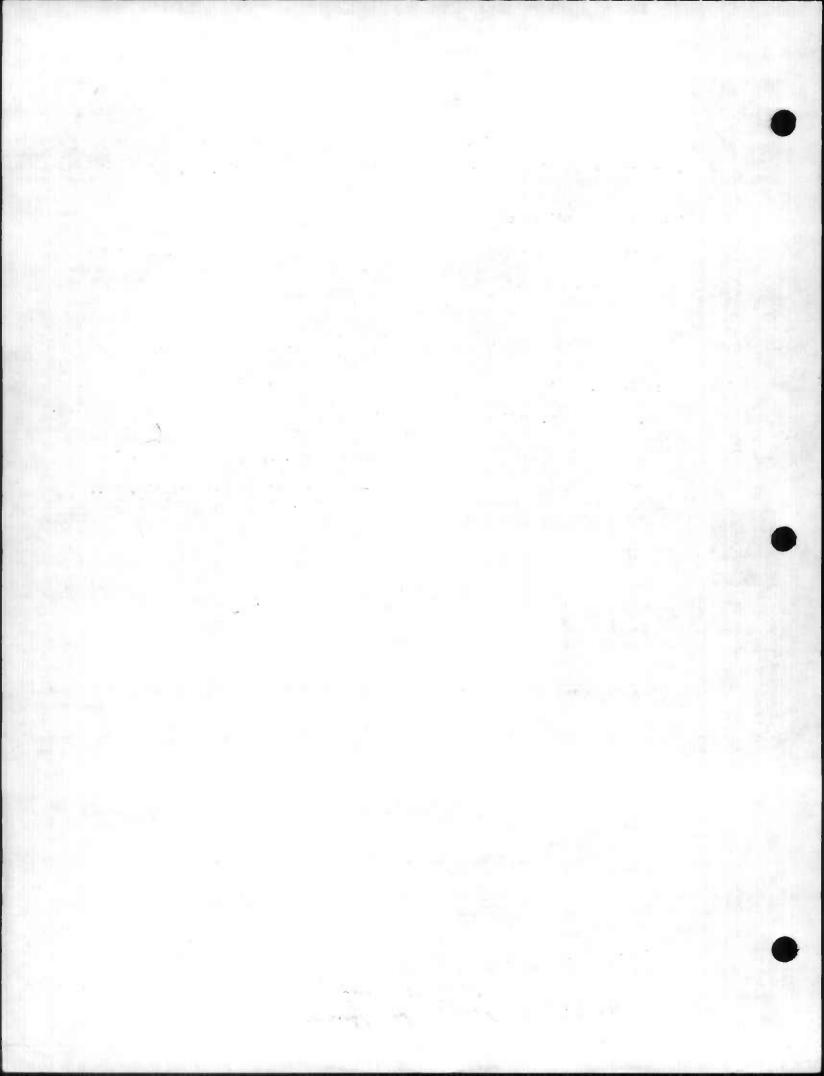
rive Baltimore Maryland

28t. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number

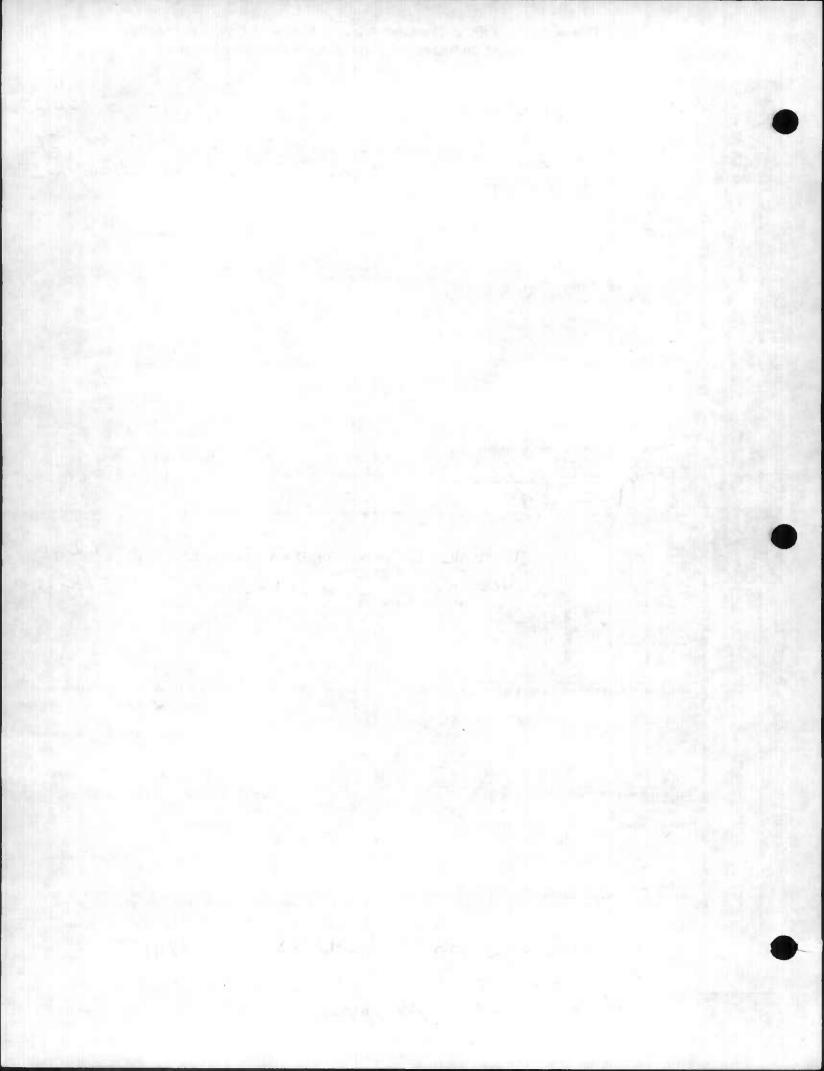


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beau No. 0 0 8679

			(Certificate of	Death		Reg. No.	00019
	1. Decedent's Name (First, Middle	Last)				2. Dete of De Month	ath Dev	3. Time of Death
Physician /Medical	SHIYENNE	YAR BROUGH	+			A -		WD 1600
Examiner	4a Facility Name (If not institution	111111111111	1 .1	1 101	4b. City, Town, or	Location of Deat	4c. County	of Death
	UNIVERSIM	of Mount	and Meo	Ucal Syst.	Bnr	more	Bn	nume Coty
Funeral	5. Social Security Number	6. Sex 7. Age	(In yrs. last birth	day) If Under 1 Year	If Under 24 Hrs	8. Date of Bir	th	9. Birthplace (State of Fereign Country)
Director	NA	1 M 2□ F	Y	rs. Months Days		(Month, De		Maryland
77	Usuet Residence of Decedent			, - , - 0			-1.	111111
ylan Mary	10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Men He To	MD N	A	Baltir	nore				1⊈ Yes 2□ No
vith the Mei tor 28a-f s be notified Director	10a. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country?
atter death with the Merylar or ferms 23a or 28a-f show refer at the motified at Funeral Director	722 E. North	Avenue		2120	2		TICA	
free death v	11. Maritat Status	12. Was Decedent E	ver in U.S.	13. Wes Decedent of	Hispanic Origin? (S	Specify Yes or No	USA 14. Race	- American Indien,
Fun Fun	1 Never Married 2 Merri	Armed Forces?	0	If Yes, specify Cul	ben, Mexican, Puer	to Rican, etc.)	Black	c, White, etc.
		If Yes, Give Year or Detes:		1 ☐ Yes 2 🛣 No	Specity:		Specify:	Black
72 hours natural;		s Education	16e. C	Pecedent's Usuai Occu	pation	de de	16b. Kind of Bu	siness/Industry
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and be fill the sed out a var	Leslie	arbrough			Taura	V	ns	
larylan 2 should be end Mental s marked o aumatic av	19e. Informent's Name/Relationsh		106	Mailing Address (Stree				State Zin Codel 03 000
								21202
2 2 2 2 2		ng	20h Place of E	Disposition (Name of	th Aven	ue Balt	imore,	Maryland City or Town, State
0 80 7	20a. Method of Disposition XIX Buriai 2 ☐ Cremation	3 □Removal from State	cemetery	cremetory or other pl	ece)	Date	200, Location - 1	Sity of Town, State
altim nit. Pag antmen ortant: injury	4 □ Donation 5 □ Other (Sp	ecify)	Mt. Z	ion Ceme	tery 0	3-17-20	000 Lan	sdowne,MD
Baltimore, permit. Pages 1 e popartiment of the Important: If ham any injury or other once.	21. Signature of Funerel Service I	icense		22. Name and Addi	ress of Facility	Baltimo	re, Man	ryland 21202
m saesa	11/2	MAI		WM.C.Ma	rch FH	1101 E.	North	Avenue
The second second	23a. Part1. Enter the disease or shock, or heart failure. List of	omplications that caused	the deeth. Do no	t enter the mode of dy	ring, such es cardia	c or respiretory e	rrest,	Approximate
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/Medical	Immediate Ceuse (Finei	12/2 m	1. 6	(+-1		60
Examiner	disease or condition resulting in death)	· Multi	pk c	rgin 3	Noorm	12.100	2	600147
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swecuted and isl-transit					rocol.	1		10073
ocertificate be swecuted rights physician and use as the burial-transit	Sequentially list conditions, if eny, leading to immediate		Due to (or as e co	nsequence oi):				1
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68760, filicate be sy physician as the buria	resulting in death) Last		ue to (or as a co	nsequenca of):				t i
M entit	THE REAL PROPERTY.	d						1
P.O. BO) at the death or d by the attend etached for us.								i
O. the de your beached hysic	Part II. Other eignificant condition	e contributing to death but	not resulting in	he underlying cause g	iven in Pert I.	23b. Dld	tobacco use con	tribute to the cause of death?
, P.O. that the detected by the detached y Physical Physi						10	Yee 2 10	3 Probably 4 Unknown
0 8 8 a			4					
The law requires to the law requires to the law seen signe page 2 should be completed by						24e. Was perfe	an autopsy ormed?	24b. Were autopsy findings available prior to
e law re e l								completion of cause of deeth?
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	25. Wes case referred to medicat				26. Place of De	ath (Check only	one)	
	axaminer?	Hospitel:	t 2 ER/Oute	petient 3 DOA	ther: 4 Nursing	Home 5 ☐ Res	dence 6 Othe	er (Specify)
Phys withis seral d	27. Menner of Death	28a. Dete of Injury	/ 28b. Ti		ury at	28d. Describe	how injury occurr	ed
On oding i	1 Maturel 5 Pending		Year) Inj		Yes 2 No			
Division of the state of the st	3 Suicide 6 □ Could n	266. Piece of inju	ry - At home, ferr	n, street, lectory, office	9			er or Rurel Route Number,
erd sing	4 Homicide	building, etc.	(Specity)			City or To	wn, Stete)	
potta ours filled	29a. Certifier 164 Certifying	Physicien: To the best of	my knowledge	death occurred at the	time dete and plac	e end due to the	cause(s) and me	nner es stated.
he Hospit in 24 hou he Funer pletely fill edical		xaminer: On the basis of end manner stet	examination end/					
DIVIS To the Hospital or Atta within 24 hours sterd of To the Funeral Directo completely filled in by ti Medical Certific	29b. Signeture end title of certifier	one mainer ster		29c, Licer	nse number		29d. Date signed	1 (Month, Day, Year)
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	- CO 40	v v	NND	D7	9187		2/11/	
0	30. Neme end eddress of person v	no completed cause of de						
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State	31. Date filed (Month Pay Year)	2000 32. Pagistra	r's Signature	9 100	,			
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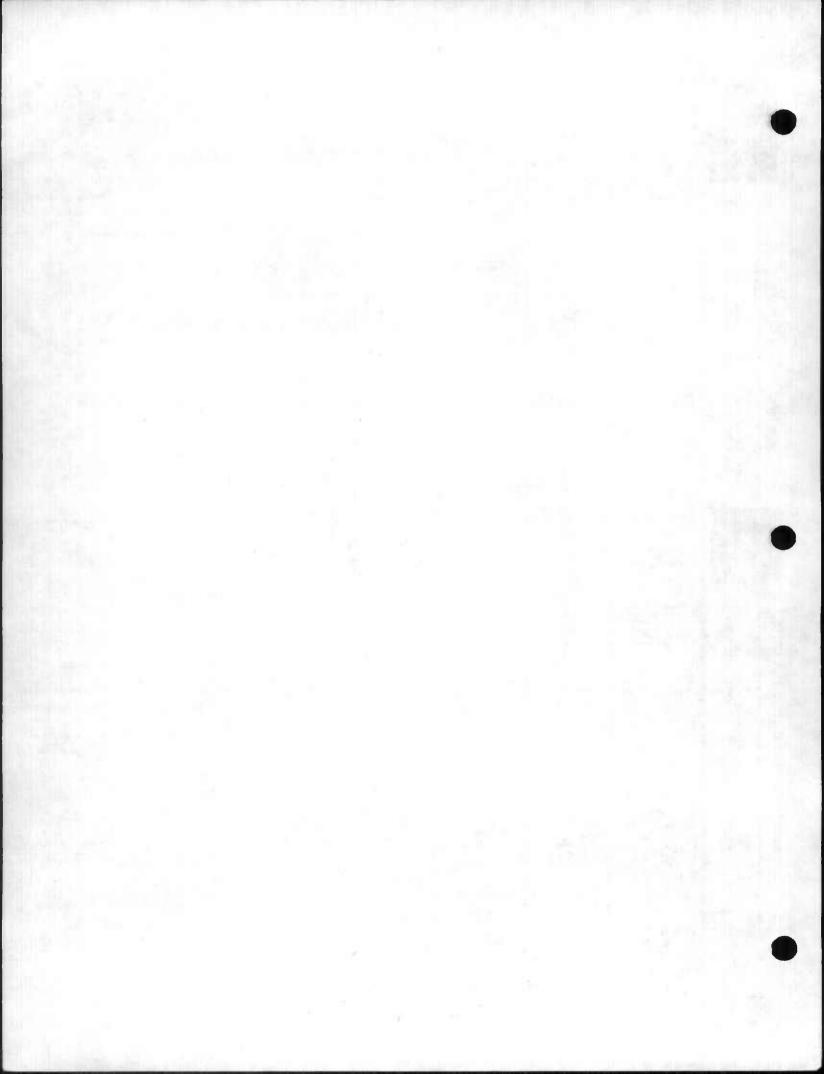
00-1414-005 Scott Andrew Zacot

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State of Maryland / Depar

rtment of Health and Mental	Hygiene	00	086	8
ificate of Death	Reg. No.	00	000	

I				Ce	ertificate of	Death		Reg. N	o	
	DI VI	1. Decedent's Nama (First, Middla, L.					2. Date of D	eath		3. Time of Death
	Physician /Medical	Scott Andr	ew Zacot				Month	11,	2000 Year	12:11 A.M
)	Examiner	4a Facility Neme (If not institution, gi				4b. City, Town,	or Location of Dea	ith 4	c. County of Death	
		Eastern Avenue Ex	tended At Br	inkmans			River		Baltimore	
	Funeral Director	220-25-6312	Sex 1 ⋈ M 2 □ F 7. Age (In 1 (In)	yrs. last birthdaj Yrs.	Months Days		Hrs. 8. Data of B Min. (Month, D JUNE 1	ony, Year	983 Ma	place (Stata or Foreign intry) ryland
	pue *	Usual Rasidence of Dacedant 10a. Sleta 10b. County	100	. City, Town or I	ocation					10d. Inside City Limits
	Maryl Heho			Baltin						1□ Yes 2□ No
	h with the Mar 3a or 28a-f e 1 be notified al Director	10e. Street and Number 7159 Cunning C:	ircle		10f. Zip Code 2122	20			itizen of What Cou	ntry?
21215-0020	within 72 hours after death with the Maryland see. Then "naturel", or items 23e or 28e-f ehow the season Exemple must be notified at morpheted by Funeral Director.	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Dates:	in U,S. 13	Was Decedent of If Yas, specify Cul		? (Specify Yes or Nuerto Rican, etc.)	lo-	14. Race - Ameri Black, White, Specify: W	
2-0	led within 72 ho ygiene. Wr than *naturn rt, mr than Completed	15. Decedent's E (Specify only highest gr		16a. Dec	edent's Usual Occu	ipation	working	16b. I	Kind of Business/In	idustry
121	ene. than	Elementary/Secondary (0-12)	College (1-4or 5+)		re kind of work done DO NOT use retin	ed)	working			
CA .	be filed within itel Hygiene. d other than event, the Be Comp	11 Sathada Nama (Sina Middle Law	A.	Stu	dent		N1		School	
and		17. Fathar's Nama (First, Middle, Last Robert Allen					Name <i>(First, Middl</i>) 1 Kunze	e, Maide	n Sumame)	
2	N 0 = 2	19a. Informant's Name/Ralationship David Zacot/und			iling Address (Stree	at and Number o	r Rural Routa Num			p Code) MD 21162
cu .		20a. Mathod of Disposition 1 □ Burial 2 ☑ Cramation 3 □ 4 □ Donation 5 □ Other (Special Content of Content o	Removal from State	cemetery, cri	oosition (Name of ematory or other pla ematory,		Date 3/12/00		ocation - City or To	
Balti	permit. Peges Department of Inportant: If ite any injury or of angles.	21. Signature of Funeral Service Live	Tisee .	C 2	remation 99 Fred	erick	ety of Rd. Bal	Mary	yland,	Inc. 21228
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J.	ed by th detache	Part II. Other arginicant conditions t	contributing to death but not	resulting in the	underlying causa g	IVON IN PART I.			1	to the cause of death?
	aw requires to should 2 should pleted							s an auto formed?	an	Vere autopsy findings vailable prior to ompletion of cause i death?
X ;	page page						10	Res 2	2 No 1	Yes 2 No
Vital	certificate rector, pa	25. Was case refarred to medical examinar?				26. Place of	Death (Check only	one)		
0	0 G	Yas 2□ No	Hospital:	2 ER/Outpatio	ent 3 DOA	ther: 4 Nursir	ng Homa 5 ☐ Res	sidence	Other (Speci	//Scene
	After th funeral funeral	27. Manner of Death 1 Natural 5 Panding	28a. Date of Injury (Month, Day Yea	28b. Time Injury	al 28c. Inju		28d/ Describe			M -
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Ž	after death Director: d in by the	3 Suicide 6 Could not be determined		t homa, farm, s	treet, factory, office		28f. Location City or To	(Street a	and Number of Bur	al Routa Number,
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7	within 24 hours after within 24 hours after To the Funeral Dire completely filled in b	29a. Certifier 1 Cartifying Ph (Check only 25d Medical Exar	ysician: To the best of my niner: On the basis of exam and mannar stated.	knowledge, dea nination and/or i	th occurred at the t nvastigation, in my	ima, date and p opinion, death o	lace, and due to the occurred at the time	e cause(: , data an	s) and manner as and place, and due to	stated. to the cause(s)
5	within 2 To the comple	29b. Signature and title of certifier	2		29c. Licen	se number		29d. Da	ate signed (Month,	Day, Year)
	0	1 lantu	Lewo			.M.E.		Mar	rch 11,20	00
	/	Name and address of person who	completed causa of death (Penn Stree	et, Balt	timore, M	aryl	and 2120	1
	State	31. Date filed (Month, Day, Year)	32. Registrar's S		6 1	-				



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March **Physician** 2000 Ann Cutler Abrahams 2054 /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Havre de Grace Harford Memorial Hospital Harford If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct. 20, 1915 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 27 F New Jersey Yrs. 213-16-4358 84 Director **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Directo Cecil Port Deposit Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 41 South Main Street 21904 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married XX Merried 1 ☐ Yes 2 ☐ No If Yes, Give \(\times \) Year or Dates: Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Bainbridge Naval Training Ctr Elementary/Secondary (0-12) Eleven Years College (1-4or 5+) Bainbridge, Maryland Postal Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be in timent of Health and Mertal H tant: If hem 27 is marked off tiury or other traumells even Willetts C. Cutler Clara M. Holden 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Wilson Abrahams, Jr. (Husband) 41 South Main Street, Port Deposit, Maryland 21904 20a. Method of Disposition

↓ □ Burial 2 □ Cremetion 3 □ Removel from State 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete Hopewell Cemetery 3/7/00 Port Deposit, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funerel Service Lice 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Sr. + CHEYDOX Perryville, Maryland 21903-0766 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by d be detact 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to 24a. Was an autopsy Be Completed completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Hospitef: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division Neturaf 5 Pending To the Hospital or Attendit within 24 hours efter death.
To the Funerel Director: A completely filled in by the fi death. investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29e, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 0

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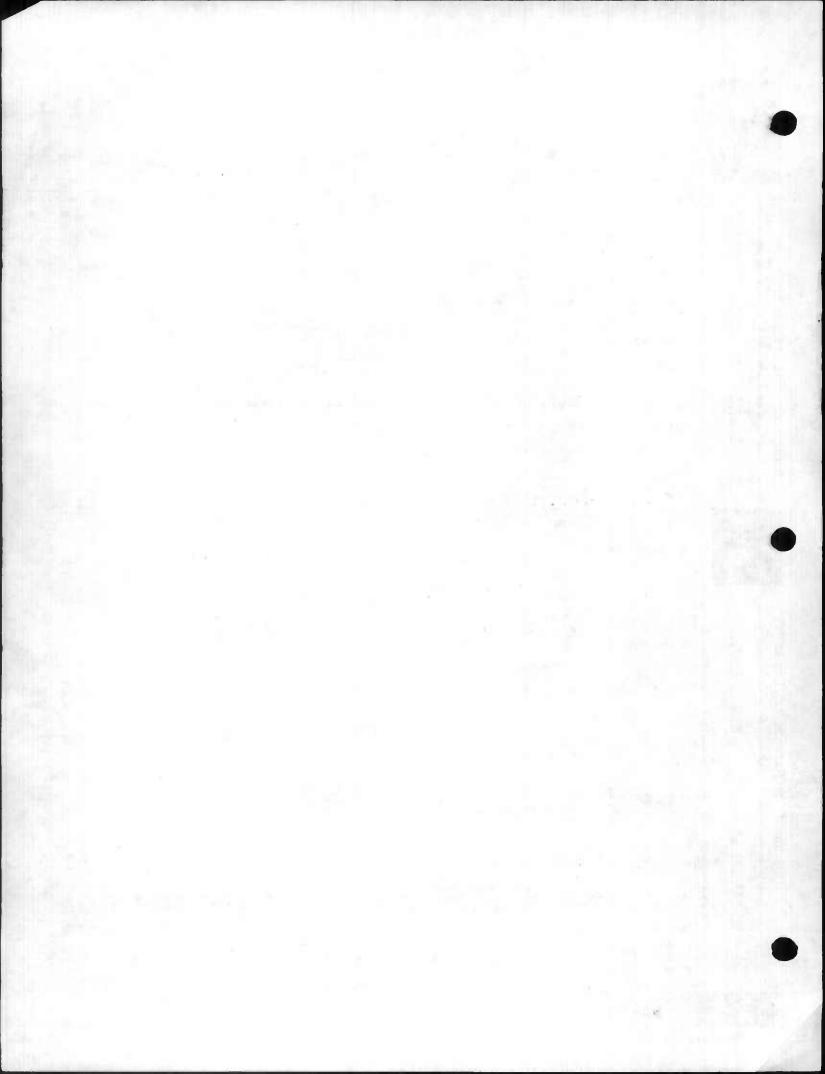
State

Registrar

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32. Registrar's Signatul



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State of Maryland / Department of Health and Mental Hygien® Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3 Time of Death 2. Date of Death ABEDINI **Physician** SAKEINEH 11:55 PM 3 00 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Shady Grove Asventist Hospital Rockville If Under 24 Hrs. Montgomery If Under 1 Year 8. Date of Birth (Month, Day, 5 2 8 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 10 M 20 F **Funeral** Yrs 49 Director Usual Residenca of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. fnside City Limita r than "natural", or items 23a or 28s-f show the Macioni Examiner must be notified at 1 Yes 2 No Director Tehran 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Iran death Funeral No:12 Rehran-Marian St Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Maritai Status e filed within 72 hours after de la Hyglena.
other than "natural", or frem 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: White p 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled will Department of Health and Mental Hyglen, Important: if Itam 27 is marked other that any Injury or other traumatic avant, ma.k. page. 6 Own Home Homemaker 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) 8 Eassa Abedini N/A 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Hamid Hajaghaje 400 E Ridgeville Blvd. Mt. Airy Maryland 21771 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition

12 Burial 2 Cremation 3 Removal from State Date 20c. Location - City or Town, State Sterling Cemetery 03/11/00 Sterling, Virginia 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral 3 22. Name and Address of Facility ce Licens Loudoun Funeral Chapel Thuse P.O. Box 1316 Leesburg, Virginia 20177 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailura. List only one cause on each lina. Approximeta Intervat Between Onset and Death **Physician** ATIC COLON CANCER fmmediata Causa (Final disease or condition resulting in daath) /Medical Examiner Dua to (or as a consequence of) Examiner attending physician and for use as the burial-transit that the death certificate be executed Sequentially fist conditions, if any, taading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of) Part If. Other significant conditions contributing to death but not rasulting in the underlying causa given in Part I. 23b. Did tobacco use contributs to the cause of death? Records, P.O. signed by t 3 Probably (Unknown 1 ☐ Yes 2 ☐ No by 24b. Ware autopsy findings aveilable prior to been si Completed 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completaly filled in by the funeral director, 25. Was case raferred to medicat 8 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 12 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. fnjury at Work? 28d. Describe how injury occurred Nature 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, atc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) title of certifier 29c. License number D44164 3.10.00 HEGAZI, MD 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)
A. Z. HEGAZI, MD 801 TOLLHOUSE, BIEF, FREDERICK MD 21701 HEGAZI, MO 801 31. Date filed (Month, Dey, Year) MAR 1 5 2000 MAR 1 5 2000 State

DHMH 16 Rev 6/95

Registrar

SAKEINEH ABEDINI 3 9 00 11:53PM

LASTI CONTESS

is a service of the s PRINCIPAL SHOP SHITZON WELL BELL TO TOWN SHEET

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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	5. Social Securit	-4692	6. Sex	M 2/2 F	7. Age (In) 84	rs. last birthday, Yrs.) If Undar 1 Year Months Days	If Under	Min. O	Data of Birt (Month, Dat C C . 3	, 1915	9. Birthp	lace (Stata or For try) 1113
	Usual Residence 10a. Stata	10b. Coun	ty		10c.	City, Town or L	ocation					10	0d. Inside City Lin
	Md.	Prin	ce Ge	orges	Во	wie							1 Yas 2
	10e. Street and	Number inchest	or La	na			10f. Zip Coda 20715				10g. Citizen of 1 USA	What Coun	try?
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Ì	19a. Informant's	s Name/Reletion	nship (Type	e, Print)		19b. Meili	ling Address (Street	and Numbe	or or Rural F	Routa Numbe	or, City or Town,	, Steta, Zip	Code)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 00 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month **Physician** Erin Charles Yitzak Bick February 28, 2000 8:24 PM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Prince Georges Fort Washington Hospital If Under 1 Yaar If Under 24 Hrs. 8. Data of Birth Months Days Hours Min. (Month, Day, Year) 8. Data of Birth (Month, Day, Year) 9. Birthplace (Stata or Foreign Country)
April 18, 1938 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** TOM 20 F 074-30-3545 61 **Director** Usual Rasidence of Decedent the Manyland 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-(show traumstic avent, the Medical Examinar must be notified at 10d. Inside City Limits Maryland Prince Georges Oxon Hill 1 ☐ Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA permit. Pages 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 28a any injury or other traumatic avent, the Medical Expenses 28a and 28a 7601 Oxon Hill Rd. 20745 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 210 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: White 1 Yes 2€No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) IBM Scientist 17. Father's Nama (First, Middle Last) 18. Mothar's Name (First, Middle, Maiden Sumama) 89 Bella. Unger Abraham 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Bick Ferguson/Wife same as item 10 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 ☐ Burial 2XXCremation 3 ☐ Removal from Stata 3/1/2000 Alexandria, VA Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Funeral Sergion Licens 22. Nama and Addrass of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Parl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximata Interval Betw Onset and Death Physician a. Cardio pulmonary Arrest

Due to (or as a consequence of):

Cardiac

Due to (or es a consequence of):

Congestive Heart Fair

Due to (or as a consequence of): /Medical Immediata Cause (Final disaasa or condition rasulting in death) Examiner Examiner The law requires that the death certificate be assouted physician and s the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Box 68760. Physician/Medical 980 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? Levebral 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ Severe Anemia 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I Be 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) Certification: To 1 Yas 25€No 27. Manner of Death 1 Delatural 2 Accident 28a. Data of injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and mennar es stated.

In the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner stated.

In the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29b. Signature and title of custiles 29c, License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) LIVINGSTON AD FT. Wash, MD 20744 O GBUANA MD 11701 01310KA 2. Régistrar's Signature 31. Data filed (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

MAR 0 2 2000

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State of Maryland / Department of Health and Mental Hygiene O 08686

Certificate of Death

			Certificate of	Death	Re	og. No.	00000
	1. Decedent's Neme (First, Middle, La	s() ₁	()		2. Dete of Deet	h	3. Time of Death
Physician	Martha	H. Laramu	rell	10.00	Month Februar		7:10 AM
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LAditifie	Citizens Nursing	T Home		Havre de	Craco		
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pun X	10a. State 10b. County	10c. City,	Town or Location				10d. Inside City Lim
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deeth with the Meryland ms 23s or 28s-f show froms be notified at	10e. Street end Number		10f. Zip Code		10	g. Citizen of Wh	nat Country?
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Mental Mental Mental out be artic eve	Jesse M. Holt			Sarah	Stoker		
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permit. Pages 1 and 2 s Department of Heelth ar Important: If Item 27 is any Injury or other trau and Injury or other trau	1 X Buriel 2 Cremetion 3	COL	metery, cremetory or other pl	ece)	2010	.oo. Loodilon · o	ny or rown, ololo
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Bramwell, Martha H.

MAR 3 LUUL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** Bertha Henson Bowles February 24, 2000 1:21pm /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ft. Washington Hospital Ft. Washington Prince George's Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Nov. 3, 1910 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 579-18-3843 1 M 2 F Washington, D.C 89 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1,□ Yes 2□ No Director Maryland Prince George's Oxon Hill or 28a-1 10e. Street and Number 10f. Zip Code 10n Citizen of What Country? 20745 560 Wilson Bridge Dr. #C-2 United States 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien. Black, White, atc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 30 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Book Clerk Dist. of Columbia 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumame) Be Pages 1 and 2 should be sent of Health and Mental Lo John Henson Lizzie unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . Department of Health a Important: If Item 27 is any injury or other trax Margaret Clemons/Daughter 560 Wilson Bridge Dr. #C-2 Oxon Hill, Md. 20745 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/29/00 Lincoln Mem. Cemetery Suitland, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Alexander S. Pope Funeral Homes omplication that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cades on each line. 5538 Marlboro Pike/Forestville, Md. 20747 23a. Part1. Enter the disease, of shock, or heart feilure. List Approximate Interval Between Onset and Death **Physician** evehral Vascular /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner sician and buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part f. 1 Yes 2 No 3 Probably 4 Unknown þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? page 2 MA 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Othar (Specify) 1 Yes 2 Ho 1 | Inpatient 2 | ER/Outpatient 3 | DOA After this 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury af / Work? or Attending 1 Natural WA MA M 5 Pending 1 Yes 2 No NIA within 24 hours after death. To the Funeral Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide NIA filled in Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. Medicai completely (Check only the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signeture and title of could 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

2000

telton

31. Date filed (Month, Day, Year)

Anderson 32. Registrer's Signature

MO

Baltimore, Maryland 21215-0020

Box 68760,

P.O.

Records,

Division of Vital

Livingston Rd

Fr. WASHINGTON-MO

MAR 91 2000 - March 19 300 10 9AM

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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DHMH 16 Ray 6/95

Registrar

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0.0

	Decedent's Name (First, Middle, Last)		Cel	rtificate of	Dealli	2. Date of Dea	Reg. No.	U	3. Time of Death
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Examiner	Southern Maryland				Clinton	SOUTH OF LOCALITY	10.000		
	5. Social Security Number 6. Sex	-	. last birthday)	If Under 1 Year		8. Date of Birth	Prince		
Funeral Director		M 2□ F 61	Vre	Months Days	Hours Min.	July 19	, Year)		laca (State or Foreig try) Lngton DC
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ect of	Maryland Prince Ge	orge's	Di	strict He	eights				-0.4
2 2	10e. Street and Number 2301 DeLano Lane			10f. Zip Code 20747	7		10g. Citizen of W USA		try?
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To etc	Clifford W. Bailey		4		Elizabeth				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08691 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Vaar MARTAN BYNUM 2:55 AM February 20, 2000 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Takoma Park Montgomery WASHINGTON ADVENTIST HOSPITAL If Under 24 Hrs. 5 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) Months Days Hours 1□ M 2₩ F 92 Yrs 578-44-1665 Feb. 2, 1908 Tennessee Usual Residence of Decedent 10c, City, Town or Location 10b. County 10d Inside City Limits 1 Yas 2 □ No Hyattsville Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20782 6500 Riggs Road U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☑ No If Yes, Give Year or Datas; Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - Amarican Indian. Black, Whita, atc. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 ☑ No Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Self-Employed Domestic 18. Mother's Nama (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19e. tnforment's Name/Reletionship (Type, Print) 9713 Docena Drive, Gaithersburg, MD 20879 Gloria B. Trueheart-Niece 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Maryland National Mem. Pk 2-25-00 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility
Marshall's Funeral Home, Inc. 21. Signature of Funeral Service Licenses 4217 9th Street N.W. Washington DC 20011 23a. Parti. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onset and Death Immediata Causa (Final diseasa or condition rasulting in death) KING Due to (or as a consequence of) Dua to (or as a consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably 4 Miknown 24b. Wara autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Dinpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner

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signed by I

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To the Hosp within 24 hos To the Fune completely fi

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Certification: To

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the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vitai

The law requires

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Hospital

death. Diractor

Physician

/Medical

Examiner

Director

Funeral

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Completed

10a. Stata

11 Marital Status

Unknown

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at

the Maryland

death

Debmit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiane. Important: If itam 27 is marked other than "natural" or any injury or other treumetic event

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical by Completed

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

25. Wes cese referred to medical axaminar? 1 Yas 2 No

28a. Data of Injury (Month, Day Year)

5 Pending invastigation 1 Netural
2 Accident 1 TYes 2 No 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and maintened on the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stelled. Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

29b. Signature and titla of certifier

29c. License number

29d. Data signed (Month, Day, Year) 20,2000

30. Nama and addrass of person who completed cause of death (ttem 23a) (Type, Print)

7610 CARRILL AVENUE, TAKOMA PARK, MD 20912 LARIMO

Registrar

8 2000 Year) 32. Registraris Signatura

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08692 Certificate of Death 3. Tima of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician Year BARKOW 1 OYCELYN EBRUARY 2,2,2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSDITAL PRINCE GEORGES -ANHAM 8. Date of Birth (Month, Day, If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days 1 M 2KF Hours Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits GEORGES Yes 2 No TRINCE MITCELLEYILLE Director 10g. Citizen of What Country? SUMFIONER COURT 20721 GUYANA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, Biack, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1□ Yes 2K No Specify: Specify: BLACK 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SPECIALIST 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be FANNIE BROTHERS UNKNOWN 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 2072/ 19a. Informant's Name/Relationship (Type, Print) 10905 SUNFIONER COURT - M. TCHECLE VIlle, MD MERYLYN J. CUMMINGS 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ST. MADES CHURCH CEMOTERY MAR 4, 2500 GUYANA 22. Name and Address of Facility SAM BUTLER + SOMS INC. 20011 21. Signature of Furieral Service Licenses TIGKENNED & ST.H.W. WASHINGTON DO NOT enter the mode of dying, such as cardiad or respiratory arrest, interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Cardiac mmuls disease or condition resulting in death) Examiner Examiner dislage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last p Stewn u Physician/Medical Due to (or as a consequence of): Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Diasetse wellit us 24b. Were autopsy lindings available prior to completion of cause of death? Chrisic Pain Completed 24e. Was an autopsy 1 ☐ Yes 20 No 2 No 1 Yes 25. Was case referred to medical examiner? 1 Yes 2 No director. 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) No Inpatient 2 □ ER/Outpatient 3 □ DOA 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

P.O. Box 68760. Records, of Vital or Attending Physician: this Affer Division

21215-0020

Baltimore, Maryland

Pages 1 and 2 should be and Mental

edical Certification: To

State

Registrar

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Completely filled in by the fun

31. Date filed (Month, Day, Year) FEB 2 9 2000

29b. Signature and title of certifier

2 Accident

3 Suicide

29a. Certifier

4 Homicide

6 Could not be

(Lewan

mitchellville

30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signatura

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28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify)

103

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

JC Shesacn

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Bonie

281. Location (Street and Number or Rural Route Number. City or Town, State)

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Physician	1. Decedent's Neme (First, Middle, La	st)				2. Date of D Month	Day	Year	3. Time of Death
/Medical	DEKINA E. D	ROWN				Februar		000	9:43 AM
Examine	4e Fecility Name (If not institution, giv 7611 INGRID PL				4b. City, Town, or LANDOVE		PRIN	of Death	ORGE'S
Funeral Director	5. Social Security Number 6. S 220-14-2254	6ex 7. Age (In yrs. 1	. rest Diritiony/	Under 1 Yeer onths Days			av. Year)	9. Birthplac Country Maryla	ce (Stete or Foreign
2 1-	Usual Residence of Decedent 10a. Stete 10b. County	10c. Ci	ity, Town or Location	on				100	I. Inside City Limits
Maryl Faho Sed a			Landover						¹X Yes 2 □ No
with the Ma Se or 28a-f s if be notified				Of. Zip Code	0785		10g. Citizen of U.S	What Country	/?
20 - after South or harm 23 unione, man		12. Was Decedent Ever In U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give		Decedent of s, specify Cul Yes 2 X No	Hispanic Origin? (Sban, Mexican, Puer	Specify Yes or N to Rican, etc.)	o- 14. Rad Bla Specifi	ce - American	0.
Maryland 21215-0020 62 should be filled within 72 hours at head Merial Hyglere. The merked other than "natural", or traumetic event, the Medical Exam. To Re Commission by 8	3 Widowed 4 □ Divorced	Year or Dates:							lack
1 21215-0 ed within 72-ho typlene. Her Medical.	15. Decedent's Ed (Specify only highest gre	de completed)	16a. Decedent' (Give kind life. DO I	of work done VOT use retin	e during most of wo	rking	16b. Kind of B	usiness/indu	stry
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yla Namen To matter	William Brown					ine Bro			
0.5 % 6	19a. Informant's Name/Reletionship (Frances 0. Hill/	Daughter	7611 Ir	ngrid I	Place, La				
altimore,	20a. Method of Disposition 1 M Buriel 2 Cremetion 3 C 4 Donation 5 Other (Specification)	Removal from State	Plece of Disposition cometery, cremeto Natural Natura Natu	ny or other pla		02/25 2000	Laurel,		
Ball	21. Signature of Funeral Service Licer	ntee	3.18 747	TENK 4 Land	TNS FUNEI	RAL HOME	over, Ma	ryland	20785
	23a. Part1. Enter the disease, or com shock, or heart feilure. List only	plicetions the caused the dea						- : A	pproximate
Physician -	Shook, or hook foliate. Elst only	one couse on each mie.							nset end Death
/Medical Examiner	Immediate Cause (Finel disease or condition resulting in death)	a CARDIO-PU	JLMONARY	Y ARRI	EST				
		CAD Due to (or es e consequen	ca of):					
8760, ate be executed hysician and the burial-transit	Sequentially list conditions, if env. leeding to immediate	b Due to (or es a consequenc	ca of):				1	9
68760, directe be experiment to be buriant as the buriant ledical E	Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	c	or es a consequenc					i	
OX 6	resulting in death) Last	d. HTN	or es a consequenc	ca orj.					
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Me Hospii n 24 hour Ne Funeri pletely fill		ysician: To the best of my known ther: On the basis of examine end menner steted.							
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(10)	Susan	L. harson	40	#	14114	{	2/2	3/00	5
(10)	30. Name and address of person who				11 11-11		0.0	0010	
State	Susan L. Laessig, 31. Date filed (Month, Dey, Year)	M.U., 106 In	eture	eet, N	.W., Wash	ington,	D.C. 2	010	
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State of Maryland / Department of Health and Mental Hygiene 00 08694

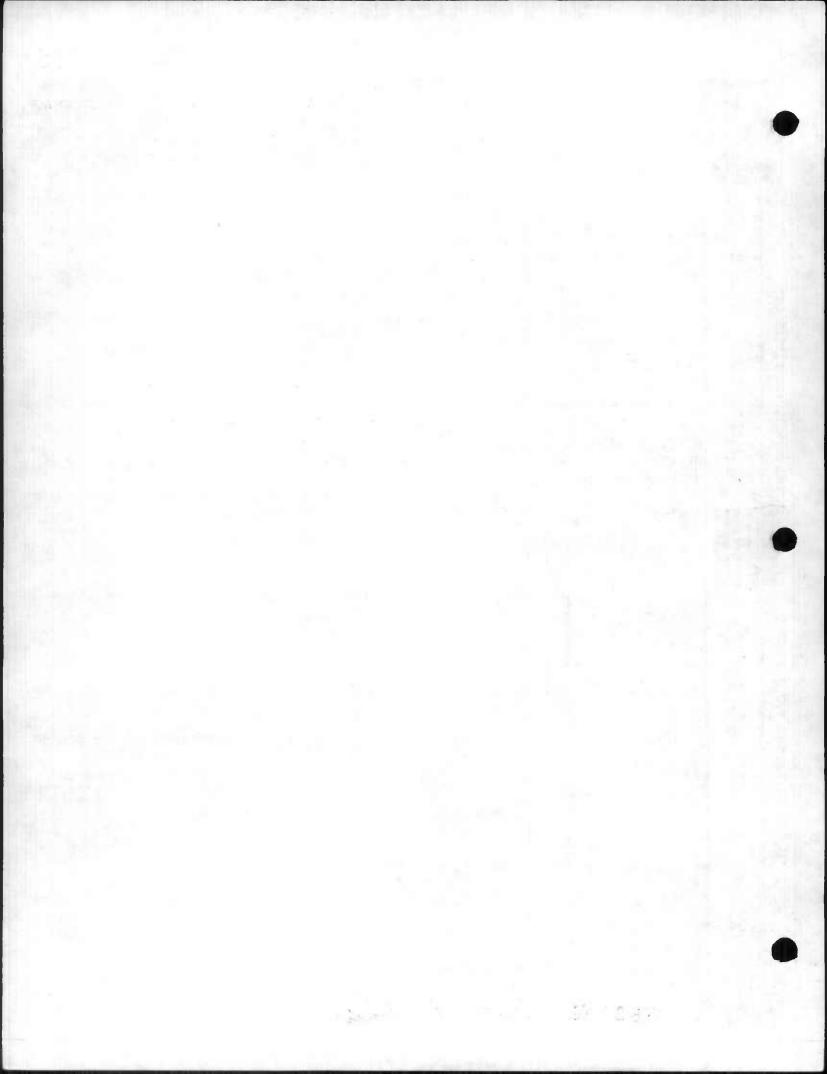
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Physician /Medical	RAYMOND THOMAS E	BOWIE				Month FEBRUAR	NY 18, 2	Year 000	3:20 PM
Examiner	4e Facility Name (If not Institution, give	re street and number)			4b. City, Town,	or Location of Deat			3.20 11
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Director	578-56-3957	18 M 2□ F 56	Yrs.	Months Days	rious	MARCH 1	10/0		NGTON, DC
p .	Usual Residence of Decedent	140.0	-						
arylan ahow dest	10a. State 10b. County	10c. C	ity, Town or L	ocation				10	d. Inside City Limits
oto oto	MARYLAND PRINCE	GEORGES CA	APITOL	HEIGHTS					1 Yes 2 □ No
or 28a-f	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	ry?
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or is		1 X Yes 2 □ No If Yes, Give		1 Yes 2 No	Specify:		Specifi		
raf.,		Year or Dates:		TE 163 ZATIO	opecity.		Specin	BLA	CK
ed within 72 hours yglene. or then "natural", it, its Medical Ex Completed by	15. Decedent's Ed (Specify only highest gra		16a. Dece	dent's Usual Occup kind of work done	ation	working	16b. Kind of B	usiness/ind	ustry
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should be nd Mental marked o urmatic evo	THOMAS BOWIE				PAULI	NE LAWSON			
A DE E	19a. Informant's Neme/Reletionship (Rural Route Numb			
the the	EDITH MAE BOWIE/S	POUSE	14868	B EMBERDA:	LE DRIV	E DALE CI	TY, VIR	GINIA	22193
- 3 mg	20a. Method of Disposition		Place of Dispo	osition (Name of matory or other ple	na)	Dete	20c. Location	City or Tov	vn, Stata
Page and of	to Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	JHemovei from Stete		COLN CEME		2/24/200	O BRENT	JOOD	MARYLAND
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death certificate be executed e attending physician and ad for use as the bunal-transit sician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	b. Metast	or as a conse	Lung quence of): 3	Diseas	e			
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has be pe 2 sh mple	14307					-		of d	npletion of cause leath?
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Physician: this certific ral director,	examiner?	Hospital:	ER/Outpatie	nt 3 DOA Oth	ior-	g Home 5 Resi		ner (Specify)
a Physical dispersion of the Tr.	27. Menner of Death	28a. Date of Injury	28b. Time o	1		1	how injury occur		
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or Attending I after death. Director: After I in by the funer	3 Suicide 6 Could not be determined	286. Place of Injury - At n	ome, farm, st	reet, factory, office			Street and Numi	ber or Rural	Route Number,
din by	4 Homicide	building, etc. (Special	(y)			City or To	wn, State)		
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director, Medical Certification: To Be (29e. Certifier 1 Certifying Ph (Check only 2 Medical Exam	yelclen: To the best of my knowniner: On the basis of examine and manner stated.	owledge, deet etion and/or in	h occurred et the tir evestigetion, in my o	ne, date end pl pinion, deeth o	aca, end due to the courred at the time,	cause(s) and me date end place,	anner es sta and due to	ited. the cause(s)
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(6)	. 10	completed cause of death (tra-	n 23e\ /T		- 1				
(4)	30. Name and address of person who TERICY JO DILE	San THESE	11 238) (Type,	LI ANIN L	Locair	H CENTE	e Clia	7011 7	MD
_				CHIVE	102111	12 2012	7 00170	0	
State	31. Date filed (Month, Day, Year)	32. Registrar's Signi	eruse						

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State of Maryland / Department of Health and Mental Hygiene

08695 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death ButleR Month Dey Year February 22, 2000 **Physician** 2:30 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 1929 9. Birthplece (State or Foreign Country) **Funeral** Months Days 1 M 2 XF Hours 70 Yrs 578-40-1236 Director September 9, South Carolina Usual Residence of Decedent 10n State 10h County 10c. City. Town or Location 10d. Inside City Limits Prince Georges 1 Yes 2 □ No Maryland Clinton r 28a-f Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9211 Stuart Lane frams 23s or frammat be b United States Mariner Nursing & Rehabilitation Center 20735 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indien Bleck, Whita, etc. 11. Marital Status 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married "natural", or I Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black ğ 3 Widowed 4 K Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry filed within Hyglens. Wher then ent, the Me Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 12th grade 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be the mark of Health and Mental Health and Mental Health art is them 27 is marked other traumatic event 80 James A. Smith Lucille Miller 19a. Informant's Name/Relationship (Type, Print) (daughter) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Willieree Twanna Murray 3425 Lumar Drive, Fort Washington, Maryland 20744 20b. Plece of Disposition (Nama of cametary, cremetory or other plece) March 2,2000 20n. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 22. Name and Address of Facility Robert G. Mason Funeral Home, INc. 21. Signature of Funeral Service Licenses 1661 Good Hope Road, S.E.; Washington, D.C. 20020 pase, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, re. List only one cause on each line. Approximete Intarvel Between Onsat and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 0 Examiner Examiner Due to (or as e consequence of) physician and the burlei-transit or Attending Physician: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or es e consequence of): 007 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown be del of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed 2 No certificate 1 Yes 1 Tyes 2 No 8 25. Was case referred to medical examiner? 26. Place of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 유 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred After Division 5 Pending investigation 1 XNatural after death. 1 Yes 2 No 2 Accident 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 6 4 ☐ Homicide within 24 hours a edicai 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and menner as stated.

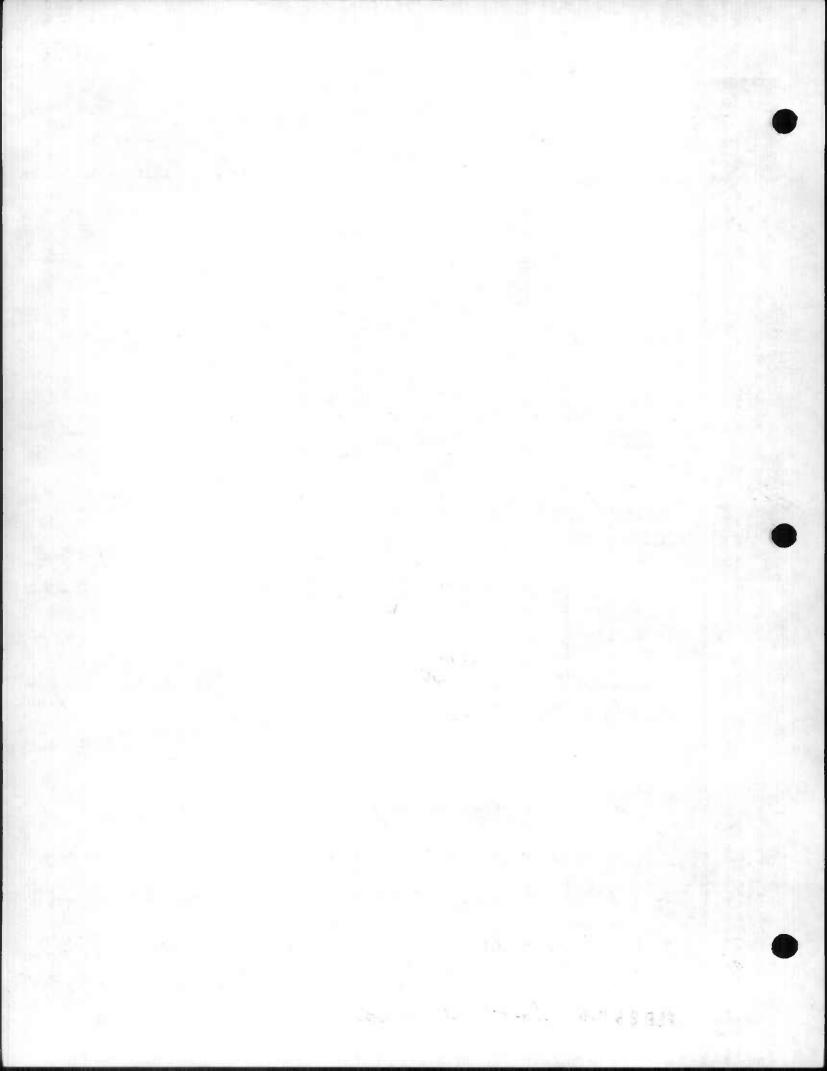
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, daeth occurred at the time, dete end place, and due to the cause(s) and manner stated. 29a. Certifier completely 2 29b. Signature and title of certifier 29c. Licensa number 29d. Dete signed (Month, Dey, Year) 365 ingdow rd # 101, for Ashingto 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michae SidaRous 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State FEB 2 9 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Patricia February 25, Brewer 2000 12:30 PM /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1□ M 21 F 47 Yrs. 214 60 6628 **Director** July 1, 1952 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or learns 23e or 25e-f show the Medical Examiner must be notified at 1 No Yes 2 □ No Maryland Montgomery Rockville Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1010 Crawford Dr. 20851 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiens. Medical Institute Elementery/Secondary (0-12) College (1-4or 5+) 12 Secretary 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be fi and Mortal F is marked of 88 Harry 10 Spencer Brewer Edith Fink Colomit. Pages 1 and 2 ah Colomitment of Health and Important: if them 37 is ma any injury or reference. 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3 Walker Ave., Gaithersburg, MD 20877 Edith F. Brewer / Mother Date 28 20b. Plece of Disposition (Name of 20c. Location - City or Town, Stete 20e. Method of Disposition cemetery, cremetory or other place) Feb. 1 ☐ Burial 2 X Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory Inc 2000 Beltsville, MD Rabpo Pandra Fally Cremation Servcies Stephen D. Lohrmann P.A. 933 Gist Ave., Silver Spring, MD 21. Signature of Funeral Salva 20910 man 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final diseasa or condition resulting in death) Examiner long Examiner N the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest and Due to (or as a consequence of): physician s the burial Box 68760 Physician/Medical Due to (or as a consequence of): for use as Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, py 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed peeu completion of cause of death? 1 Yes 20 No 1 Yes 2 No Division of Vital Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1/2 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? After i or Attanding I after death. 5 Pending investigation 1 Netural after death. Director: Aft 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homleide 24 hours a Hospital 29a. Certifier 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. edical To the Hosp within 24 ho To the Fune completely f (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, dete end place, and due to the cause(s) and manner steted. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier o of de (hom 23a) (Type, Print) 30. Name and address of person who 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

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To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the tu

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

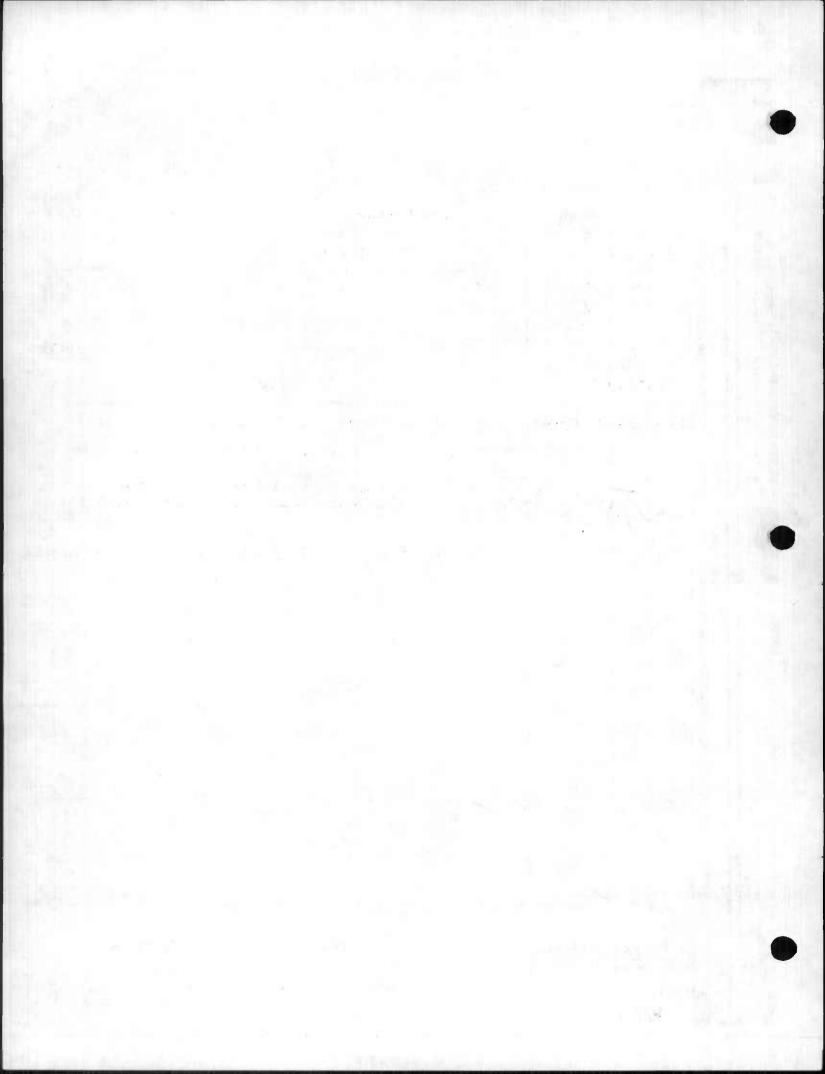
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a, Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 221313 2/29/00 1601, allen, M.

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 0 1 2000

Kin Kue Wun MD
31. Date tiled (Month, Day, Year) 223 High St. Chestertown, MD. 21620

State Registrar



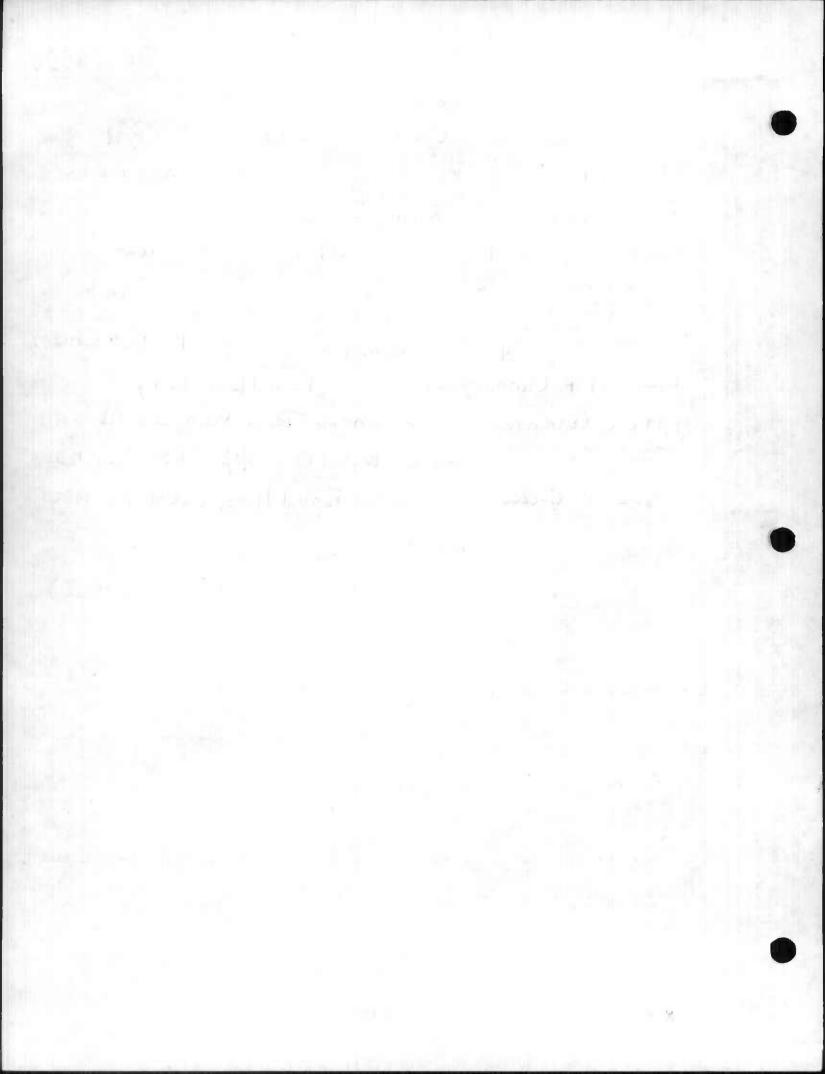
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State of Maryland / Department of Health and Mental Hygiene 08698 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Yea **Physician** 1337 Cunningham Donald E. 2000 MARCH 2 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Hospital of Cecil Count Ikton CCII 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 6. Sex If Under 1 Year Birthplace (State or Foreign Country) **Funeral** 507-34-0959 Months Deys 18 M 20 F 69 Yrs. Director Nebraska Usual Residence of Decedent 10c. City, Town or Location 10e. State 10b. County 10d. Inside City Limits pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Hasith and Mental Hygiana. Important: if Itam 27 is marked other than "natural", or itams 23s or 28s-1 shon any injury or other traumatic avant, the Medical Examinal must be notified as HD 1 ☐ Yes 2 No KISING Director Cecil 10f. Zip Code 10g. Citizen of What Country? 21911 **U.SA** 560 Chrome Koad Funeral 14. Race - American Indian, Black, White, etc. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 11. Merital Status 1 Yes 2 No If Yes, Give Year or Detes: 1 □ Never Merried 2 Married Baltimore, Maryland 21215-0020 Specity: White 1 Yes 2 TNo Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Baptist Church Elementary/Secondery (0-12) minister 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 easont F. Cunningham Fern arie 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Rising Sun MD Chrome te unnindom 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Dete 1 Burial 2 □ Cremetion 3 □ Removel from Stete 36 Line Baptist Cem 00 4 ☐ Donation 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licenses 22. Name end Address of Fecility 14363 Collins tuneral Home 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart feilure. List only one cause on each line. line Physician Immediete Cause (Finel disease or condition resulting In death) /Medical Examiner Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): attending physician of for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as e consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown P 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? INSUIN 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 2 No cartificata NON To the Hospital or Attending Physicism: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director; p 25. Was case referred to medical axaminer?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29e Certifier 29b. Signature and title of perfifier 29c. License number 29d. Date signed (Morph, Day, Year) 12 who completed cause of death (Item 23a) (Type, Print) MAR 0 7 2000 32. Registrer's Signeture State Registrar



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State of Maryland / Department of Health and Mental Hygiene

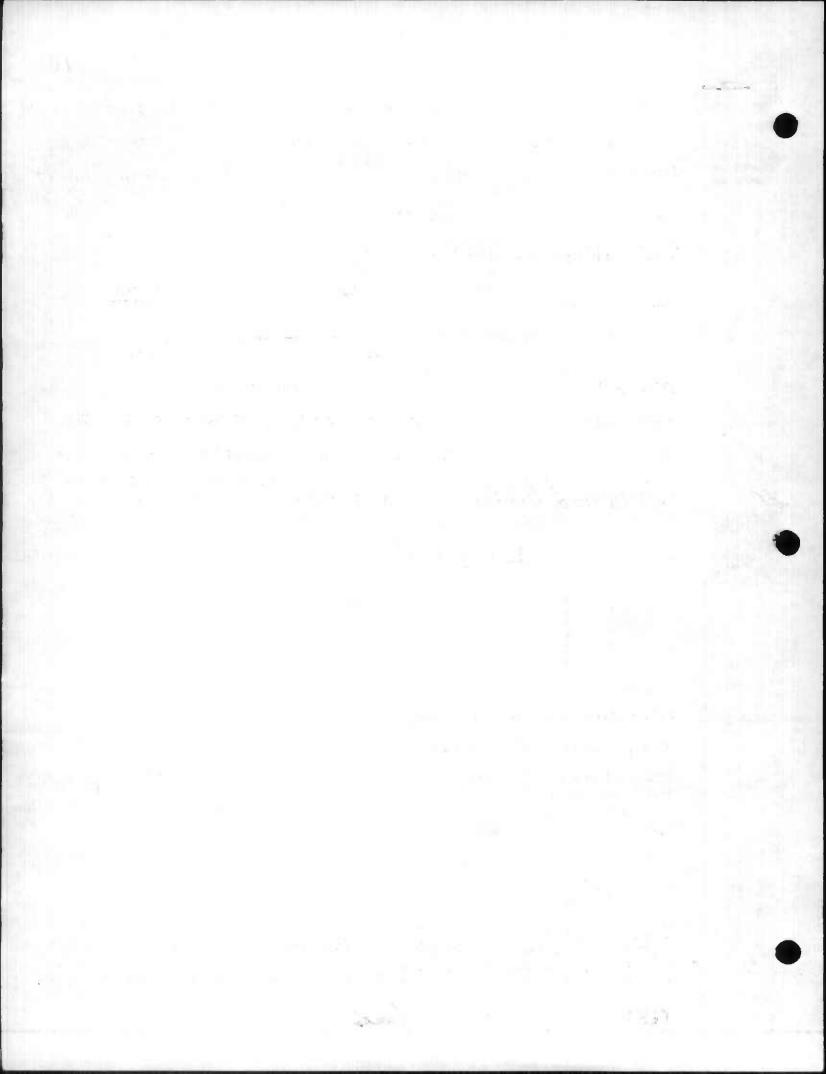
08699 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** February 23, 2000 3:55pm Eugene Herbert Carson, Sr. /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince George's Hospital Prince George's Cheverly # Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Deys Hours Min. (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F Months Deys 66 Yrs. 579-48-7437 April 4, 1933 Valhalla, N.Y. Director Usual Residence of Decedent Defamit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-i show any injury or other traumatic event, the Wedgest Expressional traumatic event, the Medical Expressional traumatics. 10h County 10c. City, Town or Location 10d. Inside City Limits TX Yes 2 No Maryland Prince George's Landover Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 7177 Mahagony Dr. United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Elder Religious 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Paul Carson Viola Holland 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marva P. Carson / Wife 7177 Mahagony Dr. Landover, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burlel 2 ☐ Cremation 3 ☐ Removal from State 2/28/00 Cedar Hill Cemetery Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Alexander S. Pope Funeral Homes 04108 5538 Marlboro Pike/Forestville, Md. 20747 comparions that caused the death. Do not enter the mode of dyling, such as cardiac or respiretory arrest, only one cause on each line. **Physician** Hrythmia ardiac /Medical Few moit. Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) 60 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be detach Renal Failur 1□ Yes 20 No 3 Probably 4 Unknown þ Hy Pertension 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? comptetion of cause of death? certificate has t irector, page 2 s 1 Yes 2 No 1 □ Yes 2 □ No Hospital or Attending Physician: funeral director, 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To Inpatient 2□ ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d Describe how injury occurred 28c. Injury et Work? Aftar 5 Pending Investigation Natural 1 Tes 2 No 2 Accident after deatl Director: 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in To the Hospital 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical pletaly 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 042580 Meyle min 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5632 Annapolis Rd # 13 Bladens Gereg MO 207/2 SAUSLA 31. Date filed (Month, Day, Year) 32. Registrer's Signature FEB 2 8 2000 Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Director			□M 20 F	91	Yrs. Months Deys	Hours Min.	8. Date of Birth (Month, Dey JUNE).	5 1908	9. Birthplace (State or Foreign Country) HQ1 S H 11, VA
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	Completed	Deep vein	throm	bosi	2		24a. Was e perfor	en eutopsy med?	24b. Were eutopsy findings aveilable prior to completion of cause of death?
rector, page 2	E	Decabitus	ulcer	5			1 🗆 Y	es 2 No	1 Yes 2 No
6		25. Wes case referred to medical examiner?				26. Piace of Deet	th (Check only or	ne)	
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inners	in o	27. Manner of Deeth 1 ☑ Netural 5 ☑ Pending	28e. Dete of injur (Month, De)	Year) 28b.	Time of njury 28c. inju		28d. Describe h	ow Injury occur	red
y the	Certification:	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Inju	irv - At home fe		Yes 2 No	28f Location (S	treet end Numb	eer or Rural Route Number,
	EL .	4 Homicide determined	building, etc	. (Specify)	erm, street, factory, office		City or Tow	n, Stete)	or or reservoir
qup	2 -	29a. Certifier 1/V Certifying Phy	sician: To the best of	f my knowledge	, deeth occurred et the ti	ime, date end place, opinion, death occur	end due to the c red et the time, d	ause(s) end ma ate end pleca,	nner es steted. and due to the cause(s)
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pletely fill	2	one) 2 Madicat Exami	ompieted cause of de	m. Joseph (Item 23e)	29c. Licens	3 2482		FEB	11,2000

Registrar



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State of Maryland / Department of Health and Mental Hygiene 08701

	Decedent's Name (First, Middle, La.	st)		ertificate of	Douth	2. Date of De	Reg. No.	3. Time of Death
Physician	Clara Louise	Crossman				Month Februar	Day	Year
/Medical Examiner	4e Facility Neme (If not institution, give				4b. City, Town, or L		-	
Examiner	Charles County Nu	The second second	hab	T	a Plata		Charles	3
Funeral	5. Social Security Number 6. S	ex 7. Age	(In yrs. last birthde	(y) If Under 1 Yeer	If Under 24 Hrs.	8. Date of Bir (Month, Da	th	Birthplace (State or Foreign Country)
Director	5//-58-3090	OM 20 F 84	Yrs	Months Days	Hours Min.			Camp Springs, MI
yland	Usuat Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
a-f-si iffed otor	Maryland Saint Ma:	ry's	Mechani	csville				1 ☐ Yes 2 ☐ No
or 25a-f s be notified	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	39563 Jarrell Dr	ive		20	659		USA	
siner mat siner mat Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U,S. 1	Wes Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Race Black	a - American Indian, k, White, etc.
6	1 Never Merried 2 Married 3 Nover Merried 2 Married	Armed Forces? 1 Yes 2 1 1 If Yes, Give Year or Dates:	lo	1□ Yes 2XXNo			Specify:	
te de	15. Decedent's Ed	lucation	16a. De	cedent's Usual Occup	pation	in a	16b. Kind of Bu	siness/Industry
Med	(Specify only highest gra	de completea) College (1-4or 5	+)	ve kind of work done . DO NOT use retire	d)	uniy		
event, the Medical. Be Completed	6th		Но	usewife			At Hom	
Be	17. Fether's Neme (First, Middle, Last)				18. Mother's Nam	e (First, Middle,	, Maiden Sumem	e)
To	Charles Payne					Hutchi		
raint	Jeanette F. Bryan		1	ame as it		ral Route Numb	er, City or Town,	State, Zip Code)
7		c, baugifter				Date	20a Laactics	City or Town, State
6	20a. Method of Disposition 1 ÅBurial 2 ☐ Cremation 3 ☐			sposition (Name of remetory or other pla				
and a	4 Donation 5 Other (Specify		Cedar I	ill Cemet	1	2000	Suitlan	d, MD.
any l	21. Signeture of Funeral Service Licen	of h		Seorge P. 5160 Oxon	Kalas Fun	eral Ho	ome, P.A.	20745
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rector, page 2 should be d	Dementie	-10	VA			10	Yes ZXXNo	1 Yes 2 No
, O	25. Was case referred to medical		• •		26. Place of Dee			
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7	27. Manner of Death	28a. Dete of Injur	y 28b. Tim	of 28c. tnju	ry at rk?		how injury occurr	
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led in by the funeral certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju-	iry - At home, ferm,	street, factory, offica		281. Location ((Street and Numb wn, State)	er or Rural Route Number,
Gerl Cerl	Tionnoise	Dunding, etc	. (Specify)			J., 01 10	, σισιο/	
Medical Certifi		ysician: To the best of	examination end/or					nner as stated. and due to the cause(s)
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50		1)	1.14		0083	70		
()	Jane	July .			0000		Februa	ry 28, 2000
/	30. Name and address of person who				. 1217 T	o D1 -+ -	MD 204	5/16_0501
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State of Maryland / Department of Health and Mental Hygiene 0 0 8 7 0 2

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Director	-		JE GEORGES		DUA	T					
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State of Maryland / Department of Health and Mental Hygiene

			Ce	rtificate	of Death	F	leg. No.	00103
Physician /Medical	Decedent's Name (First, Middle, Las Shirley	Diane (Cusato			2. Dete of Dea Month Feb 28.		3. Time of Death Year 8:50 P.N
Examiner	49 Facility Name (If not institution, give Southern Marylan	d Hospital	and thirth days	If Under 1	4b. City, Town, or Clinton Year If Under 24 Hrs	Location of Death	4c. County of Prince	George's
Funeral Director	5. Social Security Number 6. Security Number 1	M 2DF 5	rs. last birthday) 8 Yrs.		Days Hours Min.		. Year) 941	9. Birthplace (State or Foreign Country) Jashington DC
r 28e-f show	MD 10b. County P.G.		City, Town or Lo					10d. Inside City Limits 1 ☐ Yes ※X No
	10e. Street and Number 7205 Loch Raven F	toad		10f. Zip Co	20748		Og. Citizen of Wi United	
er, or hams 234 Exemples men	11. Marital Status 1 Never Married MM Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2000 No Wes, Give Year or Detes:		Wes Decedent Yes, specify	t of Hispanic Origin? (S Cuban, Mexican, Puer Me Specify:	Specify Yes or No- to Rican, etc.)		- American Indien, White, etc. White
or then "naturel", rt, the trediction Completed by	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT use	done during most of wo	rking	16b. Kind of Bus	
od other: event, the	17. Father's Neme (First, Middle, Last)		Tronical			me (First, Middle, ra Blake	Maiden Surneme	
t of Health and Mental Hyg If item 27 te marked other or other treumatic event, TO Be C	Waring Gelzer 19a. Informant's Name/Relationship (7 John A. Cusato (I		19b. Meili 7205	ng Address (S Loch	Raven Rd,	ural Route Numbe	r, City or Town, S Lngs, Ma	ry Land 20748
Department of Health Important: If flam 27 i any injury or other tr once.	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation		Plece of Dispo cemetery, cre edar Hi	matani as athe	(andana)	3, 2000		ity or Town, Stele d, Maryland
Department Important: I eny Injury o	21. Signature of Furnigal Service Liche		2:	2. Neme and	Address of Fecilityee	Funeral	Home, In	
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as been signed be 2 should be determined by PI	Sound we	ils.		3		24a. Was		24b. Were eutopsy findings available prior to completion of cause of death?
this certificate has been a rel director, page 2 should :: To Be Completed	25. Wes case referred to medical				26 Place of De	1 □ Y		1 Yes 2 No
57	examiner? 1 Yes 2 No 27. Manner Death	Hospital: 12 Inpatient 2 28a. Date of Injury (Month, Day Year)	ER/Outpatie		Other	lome 5□ Resid		
within 24 hours effer death. To the Funeral Director: After the complately filled in by the funeral Medical Certification:	1 CM atural 5 Pending		home, ferm, st	М	1 Yes 2 No	28f. Location (S City or Tow		r or Rural Route Number,
in 24 hours he Funeral plately fills edical C	29a. Certifier 1 Check only 2 Madical Exam	reician: To the best of my k iner: On the basis of exami and manner stated.	nowledge, deet inetion and/or in	h occurred at vestigetion, in	the time, date end place my opinion, deeth occu	e, end due to the curred at the time, o	ause(s) and men late and plece, ar	ner as stated. nd due to the cause(s)
To th comp	29b. Signature and tife of certifier Hery Jo 30. Name and addressed person who of	CMMD	23a) (T.m.	n	50454			(Month, Day, Year)
State		. 9801 Georgi	ia Ave.			Md. 2090	2	

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State of Maryland / Department of Health and Mental Hygiene	00	087	NL
Certificate of Death Reg. No.		001	0 1

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	-	Usual Residence of Decedent			140					-			
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-	0	Michael Crowe	9						Jane 1	. Grazio	osi		
E .		19a. Informant's Name/Relati					_				ber, City or Town		
j j		Michael Crowe	2 - F	atner					ета ка		pringfie		
any injury or other trau	2	20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic	on 3 🗆 I	Removal from	State		ematory or oth	ner plac		Date	20c. Location		
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State Registrar

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	/Medical Examiner	An Provide Blanco Man at Incate Atom at	ve street and number)				4b. City, Town, or	Location of Death	4c. County	of Death
		9440 Worrel:	l Ave				Seabro	ok	Prin	ce Georges
	Funeral Director		Sex 7. Age (In yrs. 1 N 25t F 7 0	last birthda Yrs.	(y) If Under Months	er 1 Year Days	If Under 24 Hr. Hours Mir			9. Birthplace (State or Foreign Country) New Jersey
	Du .	Usuel Residence of Decedent 10a. Steta 10b. County	10c Cit	. Town or	Location					10d. Inside City Limits
	vith the Meryla or 28a-f aho be notified at			eabro	ook					1 □ Yas 🎗 🙀 No
	after death with the Menylan or items 23s or 28s-f show mine must be notified at	10e. Street end Number 9440 Worrel	l Ave		10f. Z	ip Code 2	0706		Unite Unite	MatCountry? d States
21215-0020	S - 1	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2€ No If Yes, Give Yaer or Detas:	S. 13	3. Wes Dece If Yes, spo 1 Yes		tispanic Origin? (en, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		a-American Indien, k, White, etc. : White
		15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dec (Gr	cedent's Usi	ual Occup	pation during most of wo d)	orking	16b. Kind of Bu	siness/Industry
121		Elementery/Secondary (0-12)	College (1-4or 5+)		omema		d)		Ow	n Home
d 2	be filed within tal Hygiene. d other than event, the Me)				18. Mother's Ne	me (First, Middle,		
lan	0 6 g B A	George Manas	sse				Anne	William	ıs	
Maryland		19e. Informent's Neme/Reletionship	(Type, Print)	19b. Ma	iling Addres	ss (Street	end Number or F	iural Routa Numbe	r, City or Town,	State, Zip Code)
	1 end 2 Heeith a am 27 la	Keith Chernik					Lane	Greenbe	lt, MD	20770
Baltimore,	Pages 1 nert of He mt: If han ey or oth	20a. Method of Disposition 1 Burial 2 Cremetion 3 Donation 5 Other (Special Control of	THeurover from State		position (Na rematory or Memo			MARO 3	Olney	City or Town, Steta
Balti	Departri Departri Importa any inju	21. Signature of Fungra Service Like			22. Name e	and Addre	ss of Fecility	akoma F	uneral	Home
		23a. Part1. Enter the disease, or con shock, or heart failure. List only	pplications that caused the deet	n. Do not e						Approximate Intervel Between
Y	Physician	Stroom, or reduct failure. List only	One couse on cour mic.							Onset and Death
	/Medical Examiner	Immediate Cause (Final disease or condition	Leuken	NIA						6 months
		resulting in death)	Due to (o	r es e cons	sequenca of):				
	executed in end fal-transit		b							
ó	rificate be executed ng physicien end es the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Disease or Injury that initiated events	Due to (o	res a cons	equenca of):				
68760,	ficate be g physicie as the bur edicai	Cause (Disease or Injury that initiated events resulting in deeth) Last	C Due to (or	as a cons	equance of)):				
99 XC		lesoling in deeth) Last	d							
Вох	deeth cert e ettendin od for use	Part II. Other significant conditions	contribution to death but not con	dia - i- da -			on in Doct I	Oak Dida	-h u	tribute to the cause of death?
P.0	that the death certing of the ettending detached for use a V Physician/M		contributing to death but not rest	nting in the	undenying	cause gr	en in Parti.	1 🗆 1	mater and a	3 Probably 4 Unknown
Records,	aw requires a been sign 2 should be				J.			24e. Wes a		24b. Were autopsy findings available prior to completion of cause of death?
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Vital	certificate rector, pag							eath (Check only or	ne)	
of	F Sign	1 □ Yas 21 No		ER/Outpat		NA		Home 5 Resid		
	Affer Ing	27. Menner of Death 1 Difference 5 Pending	28e. Dete of Injury (Month, Day Year)	28b. Time Injury	of M	28c. Inju	ryat rk? Yes 2 □ No	28d. Describe h	ow injury occurr	ed
Division	or Attending lifer death. Director: After d in by the fune	2 Accident investigation 3 Suicida 6 Could not be	On Place of Injury As he	me. ferm.			165 2 110	28f. Location (S	treet and Numb	er or Rural Route Number,
	ours after eral Direction Illied in D	4 ☐ Homicide determined	building, etc. (Specify)	011001, 10010	.,, 000		City or Ton		
	Hospi 24 hour Funer may III		nysician: To the best of my knowniner: On the basis of axaminal and menner steted.	wledge, dec ion and/or	eth occurred investigation	d at the tin	me, dete and place pinion, deeth occ	e, and due to the curred at the time, c	ause(s) and me late and plece, e	nner as stated. and due to the cause(s)
	Me de la			16.11	29	9c. Licans	e number		29d. Data signed	i (Month, Day, Year)
		Bamolh	es sentera			15/2	60		03/11	100
	112/	30. Name and address of person who	-04-11-1	23a) (Typ					03/01	10-
	1	Dr. Barry Meis			eene	St.	Baltin	nore, MI	21201	
	State Registrar	31. Dete filed (Month, Day, Year)	32. Registrar's Signa	tura	1					

1005 E 0 2005

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MARCH 2000 2:25 A:M CATHERINE OLIVIA CHASE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES HUnder 24 Hrs. 8. Dete of Birth (Month, Pay, Year)
Hours Min. 1911 If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2XF Yrs. 89 Maryland Director 215-38-7274 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hama 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No MD Charles Newburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 9609 Crain Highway 20664 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Specify: Black 1 Yes 2 No Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within 7 Department of Health and Meniel Hyglens. Important: If from 27 is marked other than "na eny injury or other traumatic event, in a large page. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 6 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) 8 Elizabeth Turner Smoot John Smoot 2 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Virgie Gant/Daughter 9609 Crain Highway Newburg, MD. 20664 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) St. Ignatius Cemetery 3/9/00 Port Tobacco, MD. 22. Name and Address of Facility 21. Signature of Funerel Service Licensee 400172 AREHART-ECHOLS FUNERAL HOME, P.A. LA PLATA MD 20646 23a. Part1. Enter the disease, or complications that cause if y death. Do not e shock, or hear ballure. List only one cause on each in Approximata Intervel Batween Onset and Deeth **Physician** /Medical Immediate Causa (Finel Rays disease or condition resulting in death) Examiner ear physician and a the burlet-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Due to (or as a consequence of): 20 08A Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 Yas 2 No certificata 1 ☐ Yas 2 ☐ No Hospital or Attanding Physician:
 124 hours after death.
 Funeral Director: After this certification is the funeral director.

 Attantal director. 8 25. Was case referred to medical examiner? 26. Place of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 ☑ Hnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Matural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end dua to the causa(s) and manner as steted. To the Hosp within 24 ho To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) 3-5-80 D-46046 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) P.O. BOX 1890 GRANGE AVE. LAPLATA, MD 20646 A, MIRZA ALIKHANI MD 118 LA 32. Registrer's Signature 31. Date filed (Month, Day, Year) State

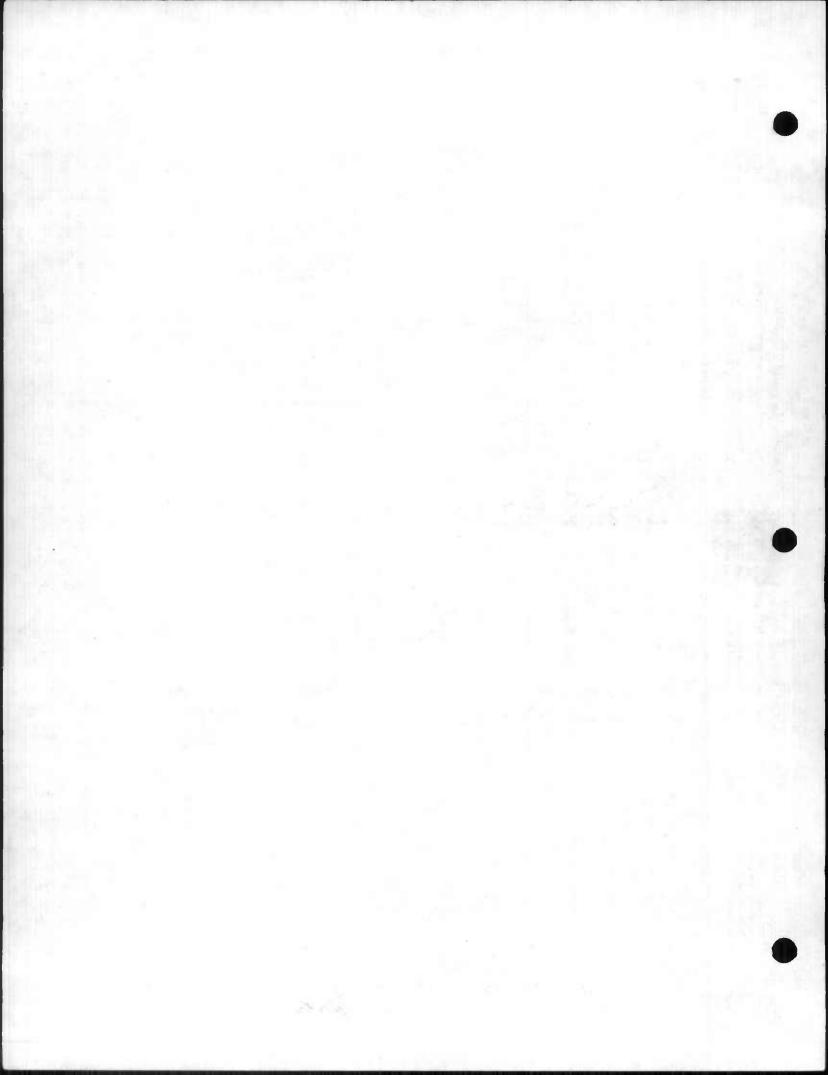
Registrar

MAR 07 2000

PATHRINE CHASE

Box 68760

Division of Vital Records, P.O.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician /Medical Examiner

Funeral Director

rai", or items 23a or 28a-f shore Examiner must be notified at Directo 'natural', or Hygiene. other than "natura ent, the Medical E filed within . Peges 1 and 2 should be fill ment of Heelth and Mental Heart: If item 27 is marked oth jury or other traumatic even

death

72 hours after

Baltimore, Maryland 21215-0020

permit. Pege Department of Important: If any injury or once. /Medical Examiner

end -tran physician er s the buriel-t 3 signed t s certificete has t this death.

Physician that the death certificate be executed Division of Vital Records, P.O. Box 68760 Attending Physician: ofter deatl 6 n 24 hours eft ne Funeral Di pletely filled in To the To the Comple

Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Day 3,2000 4c. County of Deeth JAMES LOVEJOY DICKINSON 4b. City, Town, or Location of Death 2:15 A.M. 4a Facility Name (If not institution, give street end number) CHEVERLY

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Dey, Year) PRINCE_GEORGE GLADYS SPELLMAN CONV. CENTER Birthplece (Steta or Foraign Country) 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 1QM 20F Yrs. MARCH 25,1921 NEW YORK 78 711-12-0944 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MONTGOMERY MARYLAND BETHESDA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20817 9304 EWING DRIVE U.S.A. Funerai 12. Was Decedant Evar in U,S.
Armed Forces?

No If Yes, Give
Year or Dates:

NAY Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Navar Married 2 ☑ Married WWII 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced by WHITE NAVY 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dona during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) BUILDING ENGINEER NATIONAL INSTITUTE 18. Mother's Neme (First, Middle, Meiden Sumame) OF HEALTH 17. Father's Name (First, Middle, Last) WALLACE VERNON DICKINSON ELVA PARKER 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) MARDALEE DICKINSON-SPOUSE SAME AS #10 20b. Place of Disposition (Neme of cemetery, cremetery or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State OLD DURHAM CHURCH CEM. 3-7-00 IRONSIDES, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sarvice Licensee 22. Name end Address of Facility M00479 RAYMOND FUNERAL SERVICE, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onsat and Death lune - Ventilagor dependent Immediate Cause (Final disease or condition resulting in deeth) Examiner CINDM Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Lest Due to (or as e consequence of): Physician/Medical Due to (or es a consequence of): Pert II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown py 24b. Were autopsy findings evallable prior to 24a. Wes en autopsy Completed gestive heart failure completion of causa of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medicei exeminer? 86 26. Placa of Deeth (Check only one) Hospitei: 2 EP/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yes 2♥ No Certification: To 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? 1 Natural 5 Pending 1 Yes 2 No Investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homloide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and mannar stated. 29a. Certifier Medicai (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Date signed (Month, Day, Year)

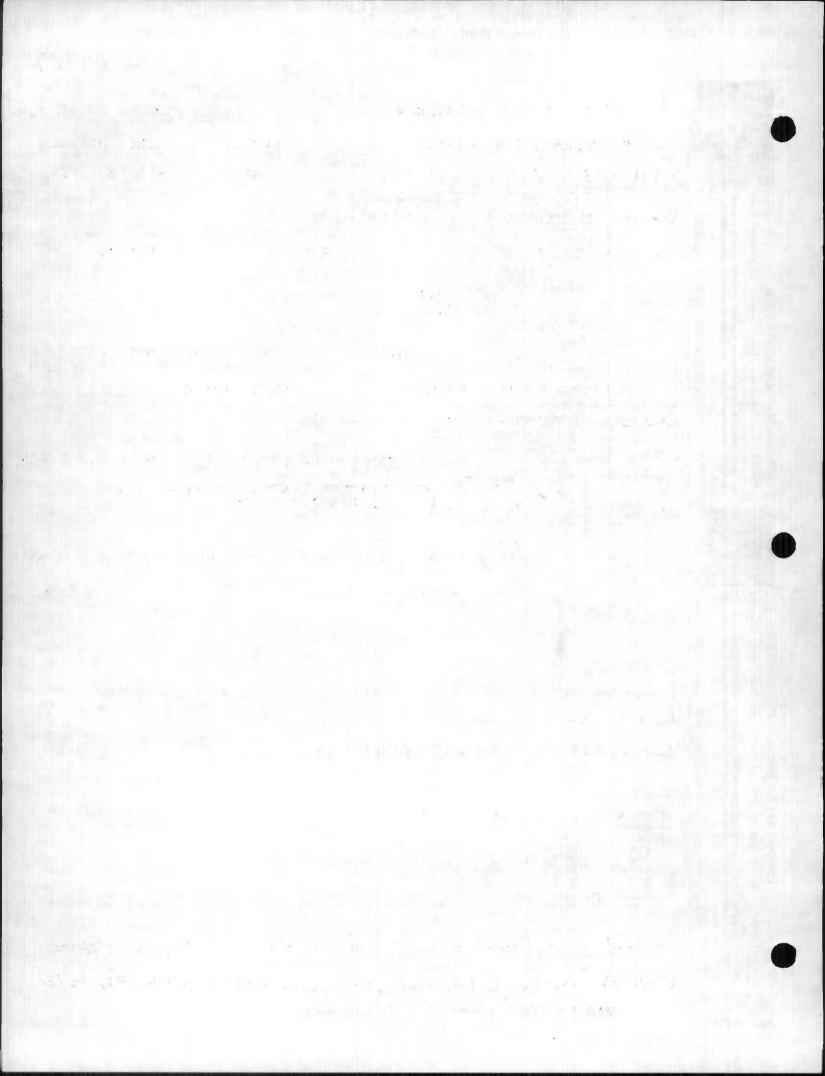
of death (Item 23a) (Type, Print)

32. Ragistrar's Signature

MD 4203 Queensbury Rd Myattsville MD

State Registrar 31. Data filed (Month, Day, Year)

MAR 0 6 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Vest **Physician** 1447 FEBRUARY 27, 2006 Larry Cleland Dodd /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner 34+h RAWIER 4113 STREET MOUNT PRINCE GEORGES If Under 24 Hrs. 8. Dale of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□F Months Deys Yrs. 577-38-7921 70 Director October 16, 1929 Illinois Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Ves 2 □ No Directo Maryland Prince George's Mount Rainier 10e, Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 4113 34th Street 20712 U.S.A. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 1 ሺ Yes 2 □ No II Yes, Give Year or Dates: 1951–1956 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14 Race - American Indian 11. Merilel Stalus Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) 12 Self Employed Musician 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Herschel Dodd Hannah Cleland 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 9209 Lanham Severn Road, Lanham, Maryland 20706 Richard J. Dodd - Son 20a. Method ol Disposition 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, State Date permit. Pages Department of Important: If it any Injury or c 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veterans Cemetery 3/1/2000 Crownsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4739 Baltimore Avenue, Hyattsville, MD Approximate Interval Between Onset and Death Immediate Cause (Final & AKTERIOSCUEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Due to (or as a consequence ol) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that Initiated events resulting in death) Las! Due to (or as a consequence of): Physician/Medicai Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were eutopsy findings available prior to 24e. Wes en eutopsy performed? Completed completion of cause of death? 2 No 1 Yes 1 □ Ves 2 □ No 25. Was cese referred to medicel examiner? 1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? Certification: 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificete be assecuted physician end the buriel-transit Division of Vital Records, P.O. Box 68760, use use signed by the e been si certificate has t lirector, page 2 s or Attanding Physician: director, this funeral After death. offer death Director: A

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"natural", or itams 23a or 28a-f ahov solical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours aftar cannot deelift and Mental Hypiene.

ont if Item 27 is marked other than "natural", or iter

ury or other traumatic event, the Modital Earn's

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Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

To the Hospital or within 24 hours eff to the Funeral Di completaly filled in WA

State Registrar

Medicai

4 Homicide

(Check only one)

29e. Certifier

29b. Signalure

30. Ne

GOLLE MARIO F. 31. Date liled (Month, Day, Year) FEB 2 9 2000

3001 32. Registrar's Signature

(Item 23e) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated

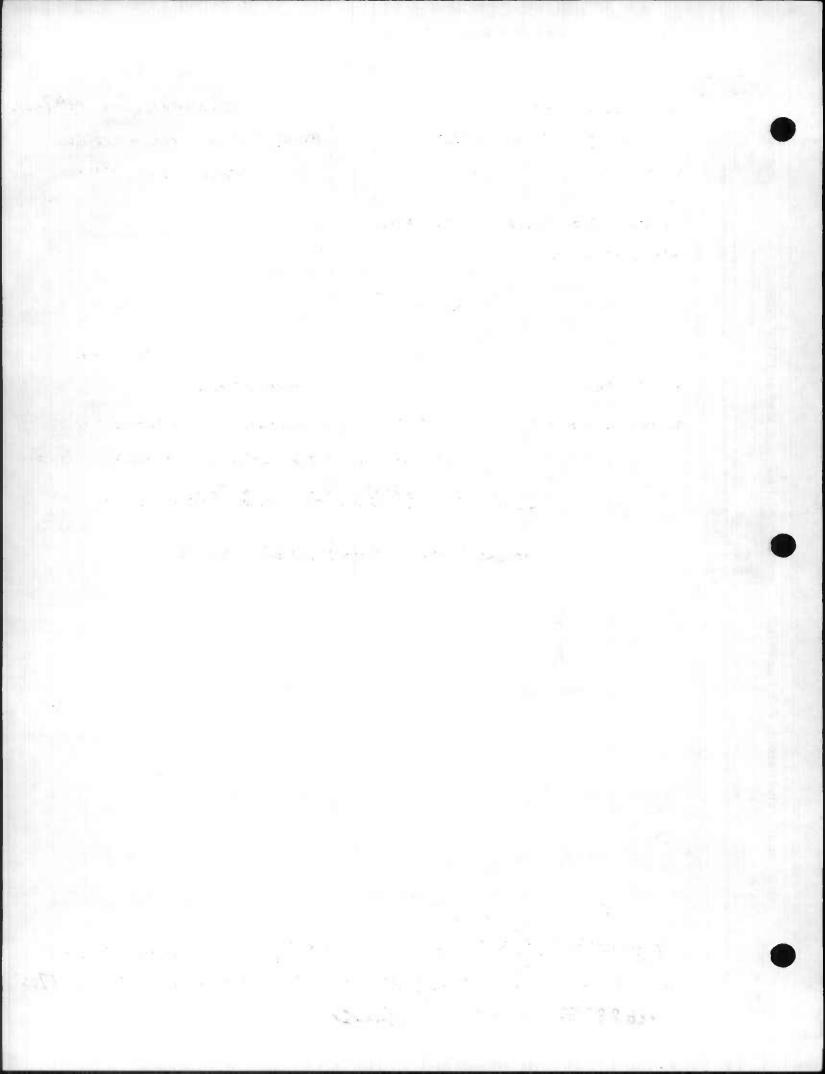
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manger stated.

29c. License number

DRIVE

29d. Dale signed (Month, Day, Year) FEBRUARY 28, 2000

CHEVERLY.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 08709

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State of Maryland / Department of Health and Mental Hygiene 00 08710

Physician /Medical	1. Decedent's Name (First, Middle, La BETTY J. DATC						-	Date of Deat Month Druary	Day	Year	Time of Death
Examiner	4a Facility Name (If not Institution, given 7620 Maple Avenu	ie, Apt #B-3		. I Millow	der 1 Year		na Par		4c. County Montg	omery	
uneral irector	,	Sex 1□M 2⊠F	(In yrs. last birtho	Month		Hours	Min.	Date of Birth (Month, Dey, ugust 7,	Year) 1931	9. Birthplace Country) North Car	State or Foreign
a or 28a-f show be notified at Director	Maryland Montgom		Takoma								side City Limits ☐ Yes 2 ☐ No
23s or 28s-f s at be notified al Directo	10e. Street and Number 7620 Maple Aven	ue, Apt #B-	3		Zip Code 20912			10	Og. Citizen of \	What Country?	
Examiner must Examiner must by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 X No If Yes, Give Yeer or Dates:			cedent of H pecify Cubs	ispanic Orig in, Mexican, Specify:	In? (Specif Puerto Ric	y Yes or No- ean, etc.)	14. Rac Blac Specify	ce - American Inck, White, etc. y: Black	
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To Be	Unknown					Ida	Mae	Robin	nson		
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ury or oth	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donalion 5 ☐ Other (Speci		20b. Placa of D cemetery, Mt.Hope	isposition (f cremetory of Bapt	Verme of or other place ist Ch	"Cemete Turch	20 20	3/04 000		city or Town, s de, Mar	
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ethe bunkling the	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	b	ue to (or as a con	nsequence (of): of):	ovdsu	oular	dis	rease	4	eaks
ached for use as hysician/Me	Part II. Other significant conditions of	d				en in Part I.			obacco usa co	ontributs to the	
2 2								24a. Was a perform	n autopsy ned?	complet	utopsy findings o prior to lon of cause
page 2								1 □ Y€	s 20 No	of death	1/
al director, pag.	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	4 C 5 D 10 11		Oth	or:		Check only on			
this call directly 100 to 100	27. Manner of Death 1 Natural 5 Pending	1 ☐ Inpatient 28e. Date of Injury (Month, Dey)	(ear) 28b. Tim Inju	ne of iry M			10		once 6 GOth	rred	ite Number
tor: After the funer cation	2 Accident investigation 3 Sulcide 6 Could not be determined		y - At home, farm (Specify)	, street, fact	tory, offica			City or Town			1011001,
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To the Funeral Director: After completely filled in by the funer Medical Certification:	2 Accident 3 Sulcide 4 Homicide 29a. Certifier (Check only) 25 Madical Exer	building, etc.	(Specify) my knowledge, d xamination and/o	leath occurrer investigati	ed at the tin	plnion, deat	place, and	due to the crat the time, do	n, State) ause(s) and make and placa,	anner as stated.	cause(s)

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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** DAVID EMANNUEL DORSEY 02-23-0650 AM 2000 /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner HOLY CROSS HOSPITAL SILVER SPRING MON1 GOMERY If Under 1 Year If Under 24 Hrs Hours | Min. Birthpleca (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Months XXM 2 F Yrs Director 577-62-5804 3-31-47 Washington, DC Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. Prince Georges Clinton XYes 2 □ No 288-7 must be notif 10a. Street and Number 10f Zin Code 10g. Citizen of What Country? Berns 23s or 8803 Temple Hill Road 20735 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 natural, or 1 ☐ Yes Mo Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondary (0-12) College (1-4or 5+) N/A 12th Plumber 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be 8 and Mental permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked t any Injury or other traumatic av 9058. Raymond Dorsey Evelyn Hyson 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Phyllis P. Dorsey/Wife 8803 Temple Hill Rd., Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Fort Lincoln Cemetery 3/3/00 Brentwood, Md. 22. Neme end Address of Facility 21. Signature/bt/Funeral Service Licensee Hackett's Funeral Chapel, Inc. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of bying, such as cardiac or respiratory errest, shock, or heert feilure. List only one cause on each line. 4 Hackla Approximate Intervel Between Onset and Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in death) /Medical Gastrointestinal Bleed 1 day = Examine Due to (or es a consequence of) Examiner Pancreatic Cancer 3 months ician and burial-transit the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of) physician a Box 68760. Physician/Medical Due to (or es a consequenca of): 980 Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco usa contributa to the cause of death? Idiopathic Thrombocytopenic Purpura 1 Yea 2X No 3 Probably 4 Unknown Records. þ P S 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Completed The 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital Physician: 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 28a. Dete of Injury (Month, Dey Year) funeral Manner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Neturei 5 Panding investigation or Attending 1 ☐ Yes 2 ☐ No death. after death Director: 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At homa, ferm, street, factory, office building, etc. (Specify) 3 4 ☐ Homicide filled in 24 hours Hospital edicai 29a. Certifier 1 Cortifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 9 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 045121 2/28/00 m 30. Name and address of person who completed cause of death (tem 23a) (Type, Print) M.D. 1500 Forest Glen Ave., Silver Spring, Md. rian F. Reagan, 31. Date filed (Month, Day, Year) 32. Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene

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		State	of Marylar				Health Death		Mental Hyg	giene Reg. No.	0	0871	Ĺ		
Decedent's Name (First, Middle, Last)									2. Dete of Dea	th Day	Year	3. Time of I	Death		
Bertram G. Dienelt								11:45	A.M.						
Facility Name (If not institution, give street and number)							4b. City, To	own, or L	ocation of Death	4c. Count	1				
Fort Washington Hospital							Fort	Wash	ington	Princ	Prince Georges				
			82 Yrs. Hunder 1 Yea			If Under	Min.	8. Date of Birth (Month, Day June 10	Y. Year)	9 Birthplace (State or					
sual Residence of	Decedent														
and the second	Prince	e Georges		ity, Town or L rt Wasi		on						10d. Inside City 1 ☐ Yes			
Da. Street and Number 10f. Zip										10g. Citizen of Whet Country?					
3100 River Bend Court 2074										USA					
. Marital Status 12. Was Decedent Ever in U Armed Forces? 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U Armed Forces? 1 ☒ Yes 2 □ No WW If Yes, Give Year or Dates:					Was Dece If Yes, spe 1 Yes	city Cut	oen, Mexica	n, Puerto	pecify Yes or No- Rican, etc.)	can Indian, etc. te					
(Specia	18a. Decedent's Usual Occupation (Give kind of work done during most of working. DO NOT use retired) Self-Employed					16b. Kind of Business/Industry									
Elementary/Secon						Tax Attorney/CPA									

Mozelle.

18. Mother's Name (First, Middle, Maiden Sumeme)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

22. Name and Address of Facility George P. Kalas Funeral Home, P.A.

6160 Oxon Hill Rd., Oxon Hill, MD 20745

Goods

3/2/2000 Alexandria, VA

24a. Was an autopsy performed?

20c. Location - City or Town, State

23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 No 3 ☐ Probably 4 ☐ Unknown

29d. Date signed (Month, Day, Year)

Approximate triterval Between Onset and Death

24b. Were autopsy findings available prior to

event, the Medical Examiner must be notified at Harna 23a or should be filed within 72 hours after Baltimore, Maryland 21215-0020 ò "natural" al Hygiene. ormit. Pages 1 and 2 sh.
Department of Heslin and h
Important if Item 27 is reany injury or oth-

Physician

/Medical

Examiner

Funeral Director

28a-f show

with the

Directo

Completed by Funeral

Be

Physician /Medical Examiner

pue

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

use as the burial-tran the Funeral Director: After this certificate hes been signed by the attending physician ipletely filled in by the funeral director, page 2 should be deteched for use as the buna

Physician/Medical Examiner Medical Certification: To Be Completed by

27. Manner of Death (1 ⊠ Netural 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

Audrey B. Dienelt/Wife 20a. Method of Disposition Immediate Cause (Finel disease or condition resulting in death) 25. Was case referred to medical 1 ☐ Yes (2 ☒ No) 5 Pending investigation

1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signatu Funeral Service Dicansee alas 23a. Part. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in death) Lest Pert II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I.

1. Decedent's Name (First, Middle

4a Facility Name (If not institution,

17. Father's Name (First, Middle, Last)

Bertram G. Dienelt

19a. Informant's Name/Relationship (Type, Print)

5. Social Security Number

718-18-7240 Usual Residence of Decedent

10a. Street and Number

11. Marital Status

10a. State

Due to (or as a consequence of) ongestive Due to (or es a consequence of

same as item 10

Metropolitan Crematory

20b. Plece of Disposition (Name of cametery, cremetory or other plece)

completion of cause of death? 1 ☐ Yes 2 3010 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

28c. tnjury at Work? 28d. Describe how injury occurred 28a. Date of tnjury (Month, Dey Year) MAM 1 Yes 2 No Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) and manner stated. 29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

Ft. Washington, MD 20744 Felton Anderson, M.D. 11418 Livingston Rd.,

31. Dete filed (Month, Dey, Year) MAR 0 3 2000

29b. Signature and title of cepil

92. Registrer's Signet

29c. License number

D41182

State

Registrar

To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifica

Same and the second of the second

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3652000 Month Year Physician 6:08 Pm Monroe Durham Feb James /Medical 4a Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Adelphi If Under 24 Hrs. Prince Georgel Heart land Care 8. Dete of Birth (Month, Day, 9. Birthplace (State or Foreign Country) If Under 1 Ye 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 10 M 2□F 75 Yrs. 24222 2714 Usual Residence of Decedent Director the Manyland 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Show must be notified at Prince George's 1 Yes 2 □ No **Funeral Director** WD Ad288-1 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 23a or death with 20783 USA 1801 Metzerott 14. Race - American Indian, Black, White, etc. под 11. Marital Status 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 6 1 Yes 2 No Specify Black Completed by 3 Widowed 4 □ Divorced "natural". 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employed Carpenter other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hant: If them 27 is marked oth jury or other traumatic even illie Williams Dutham mae Inomas 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 5497 A. Holmes Run Pankway , Alexandria, VA 22304 Fitzgeralo Beretly 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Mate 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from Stete 4 Donation 5 Other (Specify) permit. Page Department of Important: If eny Injury or once. 3 mpn 00 Metropolitan Crematory 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility GREENE FUNERAL HOME E Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Fine) disease or condition resulting in death) 0 Examiner Due to (or es a consequence of): Physician/Medical Examiner Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest and Due to (or es a consequence of): P.O. Box 68760, the Due to (or es a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yaa 2 No 3 Probably 4 ™Unknown Division of Vital Records, Be Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? has certificate 1 Yes 20 No 1 ☐ Yes 2 ☑ No director, 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospital: 1⊠ Inpatient 2□ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 3D DOA this 28a. Dete of Injury (Month, Day Year) funeral 27. Manner of Deeth 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 5 Panding investigation 1 Netural death. 1 Tyes 2 No To the Hospital or Attendition within 24 hours after death. To the Funeral Director: A completely filled in by the form the 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as steted. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 27

State Registrar 31. Dete filed (Month, Day, Year) MAR 0 1 2000

ss of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

GHESNE FINCRA SIG Franco Sil Ale antic ya

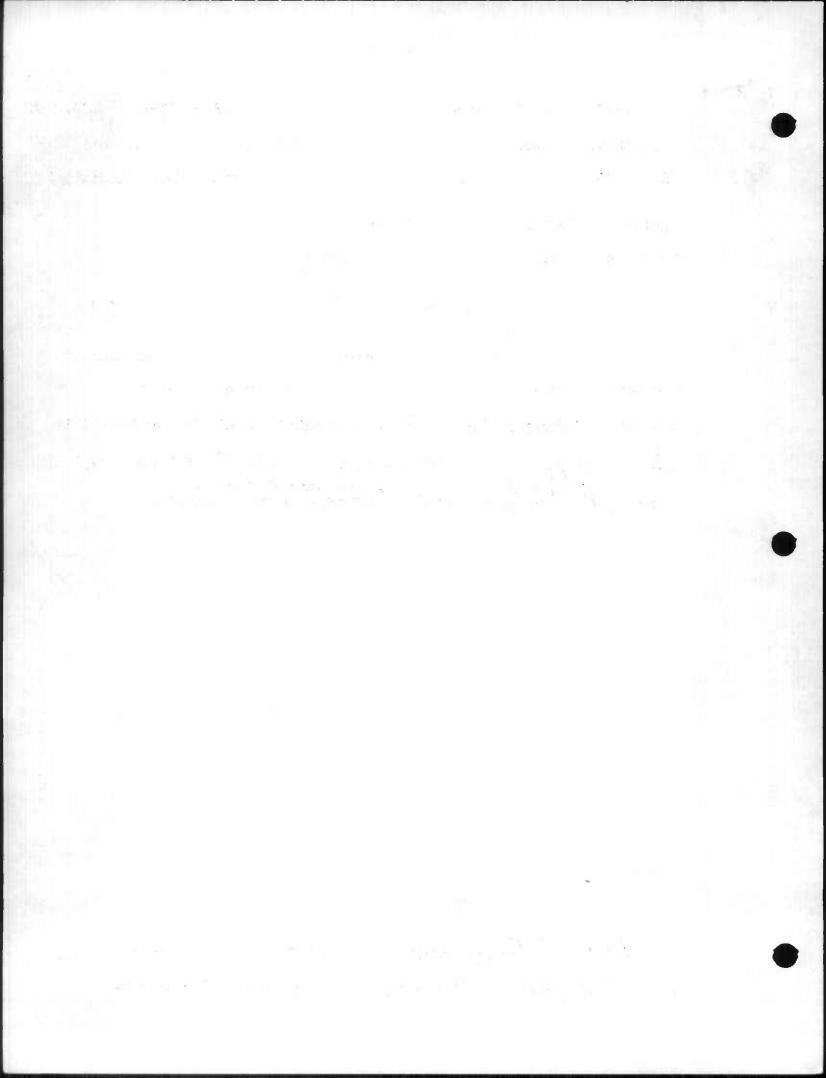
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legibie.

State of Maryland / Department of Health and Mental Hygiene

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/Medi			Donald Kondall Dolanov								March 2				2000 Yeer 10:				
	Exami		4e. Facility Name (If not institution, give street end number)							4b. City, To	wn, or Lo	ocation of Dea	th 4	c. County					
Fune			207 Hille	endale	Rd.					Be]	el Air Harford								
	Funeral		5. Socisi Security Number 6. Sex 7. Aga (In yrs.					last birthday) If Under 1 Ya Months Dev			24 Hrs. Min,	8. Dete of B (Month, D	rth	r)	9. Birthp	Birthplace (State or Foreign Country)			
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	ges 1 and 2 should be filed within 72 hours efter death with the Maryland it of Health and Mentel Hygiene. If Itam 27 is marked other than "natural", or itams 23s or 28s-f show or other traumstic avent, the Medical Examinar must be notified at	100	Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code									10g. Citizen of What Country?							
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21215-0020	n 72 hours efter of natural, or iter	by Funeral Director	1 Never Merried 3	-	Armed Fore	Armed Forcas? ↑♥️ Yes 2 □ No If Yes, Give Year or Detas:1948-52				, Puarto	Rican, atc.)		ck, White,	k, White, etc. White					
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Maryland	should and Man a marke	1									ural Route Number, City or Town, State, Zip Code)								
	th er		Dr. Jean M.			fe		•				, Bel Air, Maryland 21014							
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Baltimore,	Pa Pa		20a. Method of Disposition 1 Disposition 20b. Plece of Disposition (Neme of cematary, cremetory or other place) 4 Dophellon 5 Date 3-6-00 Highview Memorial Gardens 20c. Location - City or Town, State Fallston, Maryland																
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	Physician Medical Examiner		23e. Ralt 1. Enter the disease, or obspications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errest, shock, or heert feiture. List only one cause on each sine. Approximete Intervel Between Onset and Deeth																
1			Immediate Cause (Final disease or condition resulting in deeth) e. Post Chstrictive Prevmenia 2 menths																
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68760,	te be ysicl	edicai	Sequentielly list conditions, if eny, leeding to immediate cause. Enter Undarlying Cause (Disease or Injury that initieled events considered the condition of t												-				
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3	Physician: The this certificata ral director, pag	Be	exeminar /									eeth (Check only one)							
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E C	ifing Ph After th funeral	Certification:	27. Menner of Deeth 1 Neturel 5 □	Pending	28e. Dete of Injury (Month, Day Year) 28b. Tima of Injury 28b. Tima of Work?				28d. Describe how Injury occurred										
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≥	rect rect	E I	3 Sulcide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)								1	281. Location (Street end Number or Rural Route Number, City or Town, Steta)							
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	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edicai	29e. Certifier (Check only one) 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner as stated. 2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred et the time, dete end plece, end due to the ceuse(s) and manner steted.											ise(s)					
	Withi To th	×	29b. Signatura and title of	certifier				290		a number		29d. Date signed (Month, Day, Yea				ar)			
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1, Decedent's Nama (First, Middle, Last) FEBRUARY 23, 2000 1310 GRACE L. ELAM 4c. County of Death 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death LANDOVER PRINCE GEORGES 7738 BENDER ROAD If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 1□M 2X)F 73 Yrs. 242-36-7534 June 15, 1926 North Carolina Usual Rasidance of Decedant 10a State 10b County 10c. City, Town or Location 10d. Insida City Limits 1 X Yes 2 □ No Prince George's Mary land Landover 10e. Straat and Number 10f. Zip Coda 10g. Citizen of What Country? 7738 Bender Road 20785 U.S.A. 14. Race - American Indien, 11. Maritel Status 12. Wes Decedent Evar in U,S. Armed Forcas? Was Decedant of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) Bleck, Whita, atc. 1 ☐ Yas 2 ☑ No If Yas, Giva Yaar or Datas: 1 □ Navar Married 2 □ Married 1 ☐ Yes 2 No Specify: Specify: Black 3 X Widowed 4 □ Divorced 16a. Dacedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Spacify only highast grada completed) (Giva kind of work done during most of working lifa. DO NOT usa ratired) Elamantary/Secondary (0-12) College (1-4or 5+) Chef Private 12th 18. Mothar's Nama (First, Middla, Maiden Surnama) 17. Fathar's Nama (First, Middle, Last) Matthew Eichelberger Sarah Corpening 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) 7738 Bender Road, Landover, Maryland 20785 Lorinda Elam/Daughter 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 03/02 1 ☒ Burial 2 ☐ Cramation 3 ☐ Ramoval from State Maryland Veterans Ceme. 4 ☐ Donation 5 ☐ Other (Specify) 2000 Cheltenham, Maryland J. B. JENKINS FUNERAL HOME 21. Signetura of Funeral Service Licensee 23e. Pertl. Enter the disease or complications that caused the death. Do not antar the mode of dying, such as cerdiac or respiretory arrast, shock, or heart failers. List only one cause on each line. 7474 Landover Road, Landover, Maryland 20785 Approximata Intarval Between Onsat end Death Immediata Causa (Final disaasa or condition rasulting in daath) . HYPERTENSIVE ARTERIOSCUEROTIC CARDIOVASCULAR PISEASE Due to (or es e consequence of) Sequantially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Diseasa or Injury that Initiated evants resulting In deeth) Lest Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the ceuse of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy 1 Yas 2 No 1 TYes 2 No 25. Was casa refarred to medical 26. Placa of Death (Chack only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2□ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) Menner of Deeth 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Panding investigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be determined

physician and s the buriel-transit law requires thet the death certificate be axecuted Division of Vital Records, P.O. Box 68760. 88 attending for use as signed by the a s need should Completed has e 2 is certificete had Hospital or Atlanding Physician: 24 hours after daath. 2 this funeral After To the Hospital or Attendit within 24 hours after death.

To the Funeral Director: All complately filled in by tha fu

Physician

/Medical

Examiner

Funeral

Director

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Physician

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Physician/Medical

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Funeral

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Completed

72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

State Registrar 29b. Signature and title of 30. Nema and addrass of person who

28e. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated.

29c. License number

29d. Data signed (Month, Day, Year)

FEBRUARY 24, 2000

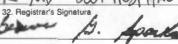
ted cause (Meath (Item 23a) (Type, Print) GOLIE MARIO F.

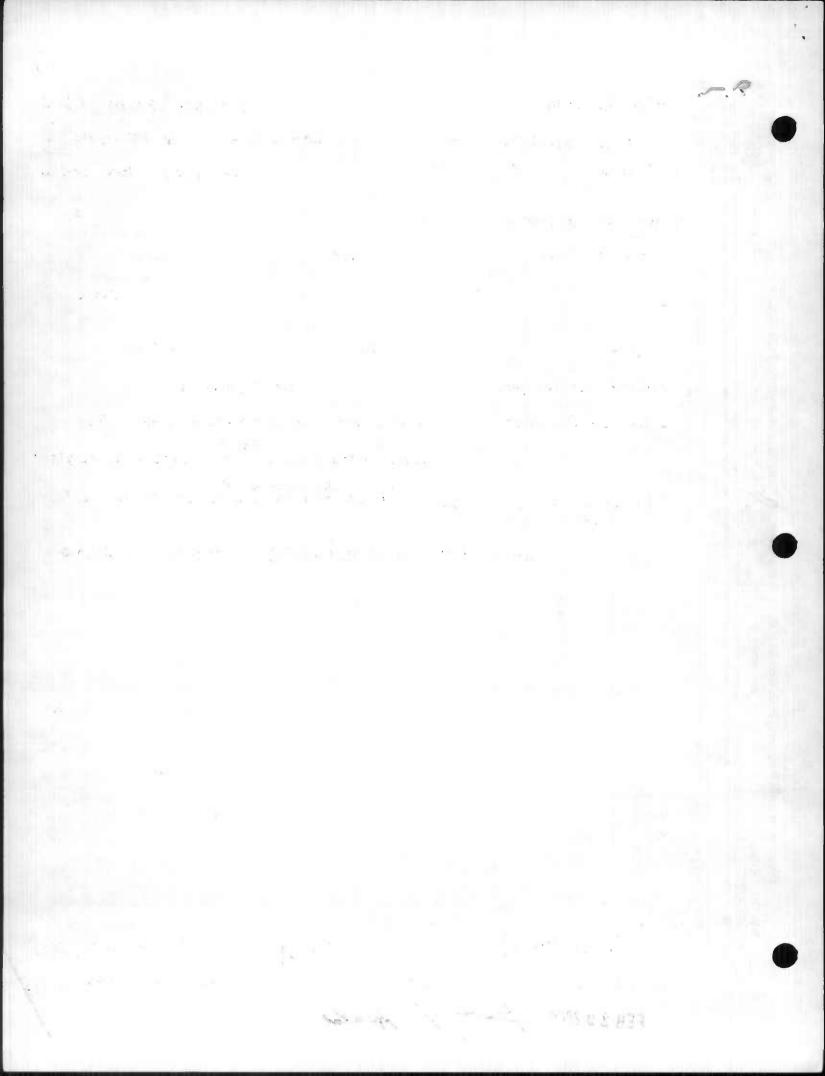
MC 3001 HOSPITAL

DAUG, CHEUBRLY

MARYLAND 20785

31. Data filed (Month, Day, Yaar) FEB 2 9 2000





State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2 4 2000 Feb 12:30pm EPPS Sr. JOSEPH /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Prince George"s Upper Marlboro 79 Herrington Drive If Under 1 Year If Under 24 Hrs. 8, Data of Birth

Hours Min. (Month, Dey, Year) Birthplace (Steta or Foreign Country) 5. Social Security Number 6. Sax 7. Aga (In yrs. lest birthday) **Funeral** 1**X** M 2□ F Yrs. **Director** 22 7165 Mar 5 1925 Washington DO Usual Rasidence of Dacedant the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1√2 Yes 2 No Directo Prince George Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 79 Herrington Drive Funeral 20774 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puanto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □XYes 2 □ No If Yes, Giva Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 9th House Keeper Federal Government traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) 12 should be fi h end Mental H is marked off Smith Olivia 10 Lucius Epps 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Peges 1 and 2.
Department of Health el
Important: If Item 27 Is
any injury or other trau 79 Herrington Dr. Upper Marlboro, Md. 20774 Teresa Moore, Daughter 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition 1 Nurial 2 Cremation 3 Removel from State 4 Dogellon 5 Other (Specify) Quantico Nat Cemetery3/1/00 Triangle, Va. § □Other (Specify) 22. Nama and Addrass of Facility HALL BROTHERS FUNERAL HOME 20001 Rith C. Hall 621 Florida Avenue, NW, Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Chronic diseasa or condition resulting in deeth) a Coronary Artery Disease Examiner Due to (or as a consequence of): Examiner 5 CLEROSIS b. Amyotropic Lateral be executed physician end the buriel-trans Sequentially list conditions, if any, leading to immadiate ceuse. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): DISEASE Box 68760 Peripheral Vascular Physician/Medical thet initieted events resulting in death) Last Due to (or as a consequence of) 88 esn 0 23b. Did tobecco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. P.0. the signed by the 1 Yes 2 No 3 Probably 4 Unknown Neuropathic Bladder by 24b. Were autopsy findings available prior to 24a. Was en autopsy Completed Sacral Decubiti completion of cause of deeth? has page 2 1 Yas 2 No 1 ☐ Yas 2 ☐ No Division of Vital funeral director, Be 25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital; 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🕅 Residence 6 ☐ Other (Specify) To 1 Yes 2 No 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Yeer) 28b. Time of 28c. Injury at Work? Certification: 5 Pending 1 XNatural after death. 1 Yes 2 No Investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital
With 24 hours a
To the Funeral Completely Illed 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.

2 Madical Examinar: On the basia of examination and/or investigetion, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. Licansa number 29d. Data signed (Month, Dey, Year) test D 0054991 completed cause of deeth (Item 23e) (Type, Print) 30. Name end address of person who Capitol Heights, Md. 20743 Robert Ball, MD. 1458 Addison Road South,

Registrar

FEB 2 8 2000

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** ROBERT C, EDWARDS FEBRUARY 26,2000 11:20am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Hours Days 488-07-6428 Director 87 July 9,1912 **Illinois** Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Maryta Md. 1 Yes 2 No Montgomery Silver Spring Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 munt be 1220 East West Highway #321 238 20910 U.S.A. Funeral Berns : 12. Was Decedent Ever in U,S. Armed Forces? 12. Was 2 □ No 1 3Mar 4 3 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Hygiens. other than "natural", or lise ent, the Medical Examiner Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 If Yes, Give Year or Detes: 18Nov44 1 ☐ Yes 2XXVo Specify: þ 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Salesman Private 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be nent of Health and Mental Unknown Unknown 19a. tnformant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) nt of Health a i: If Item 27 is or other tras. 1220 East West Highway #321 Silver Spring Md 20910 of Disposition (Nama of Date 20c. Location - City or Town, State Olethia Edwards/Wife 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 1 ABurial 2 Cremation 3 Removel from State Department of Important: If any Injury or Jefferson Barrack 3/3/00 St. Louis, Mo. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Lic Johnson & Jenkins Inc. 716 Kennedy St., N.W. Washington D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiratory arrest, ahock, or heart tailure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical Examiner Examiner sician and burial-transit Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be execu physician s the burial Box 68760. ۵ Physician/Medical Due to (or as a consequence of): 88 for use signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ò 24b. Wara autopsy tindings available prior to completion of cause of death? Completed 24a. Was an sutopsy performed? **page 2** 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vital or Attending Physician: director, Be 25. Was case refarred to madicat 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes ¾XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. tnjury at Work? 28d. Describe how injury occurred 28b. Tima ot After 5 Pending investigation 1 (XNatural 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accidant 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, tarm, atreet, tactory, office building, etc. (Specify) filled in by 4 Homicide Hospital Certifying Physician: To the best of my knowledga, daath occurred at the time, data and place, and due to the cause(s) and mennar as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier Medical npletely (Check only one) 5 29b. Signature and title of certifie 29d. Deta signed (Month, Day, Year) 0 2000 30. Nama and address of person who completed causa of death (Hem 23a) (Type, Ilview DR Beltsville, Me 055, M JUSAN 31. Date tiled (Month, Day, Year) 32 Registrar's Signature State MAR 0 1 2000

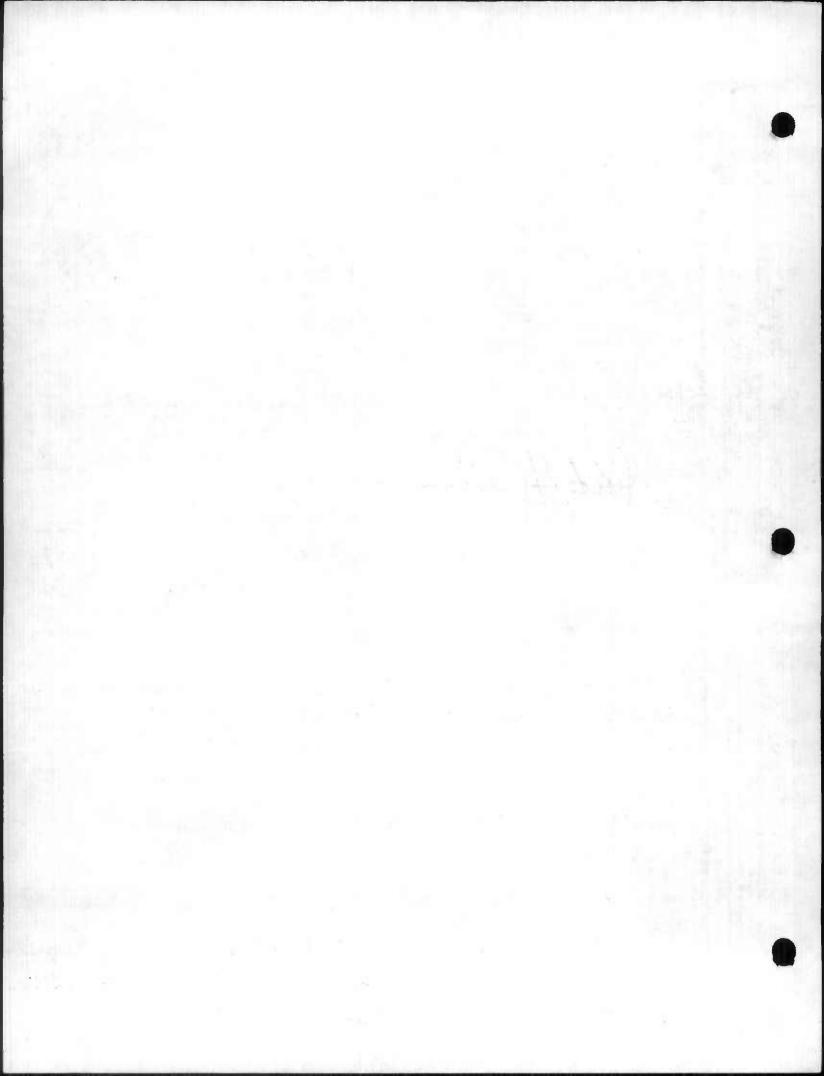
DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 00 08720

			Ce	rtificate of	Death	1	Reg. No.			
B1 ::	1. Decedent's Name (First, Middle, Li	nst)	matumi.			2. Date of Dec Month		Voor	3. Time of Deeth	
Physician /Medical	LOIS	REGINA	F0	WLER		March	4 ^{Dey} 2(000	1:30 AM	
Examiner	4a Facility Neme (If not institution, gi				4b. City, Town, or L					
	Southern Maryla	nd Hospital	Center		Clin			ce Ge	orge's	
Funeral		· Clar office	(In yrs. last birthday)	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h y, Year)		laca (State or Foreign try)	
Director	219-54-6065 Usuet Residence of Decedent	7 ZWF 7	1 Yrs.			May 28	, 1928	Mary	Tand	
DO 2 10	10a. State 10b. County		10c. City, Town or Le	ocation				1	0d. Inside City Limits	
Mary leght	Maryland Char	les	LaPl	ata					1 Yes 2 No	
vith the Maryland or 28e-f show be notified at Director	10e. Street and Number			10f. Zip Code		1	10g. Citizen of	Whet Coun	trv?	
2 4 0	122 West Hawthor	ne Drive			20646		U.S.	Α.		
ther death with the Marylar ritems 23a or 28e-f show siner must be notified at Funeral Director	11. Marital Status	12. Wes Decedent Ex		Was Decedent of I	lispanic Origin? (Sp	pecify Yes or No-	14. Rac	e - Americ		
1 FE IL	1 Never Merried 2 Married	Armed Forces?			an, Mexican, Puerti	o Hican, etc.)		ck, White,	etc.	
by Est	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Detes:		1 Yes 2 No	Specify:		Specif	Whi	te	
yolers. Ne than 'natural, it the Medical Completed	15. Decedent's E (Specify only highest or		16a. Dece	dent's Usuel Occup	pation	kina	16b. Kind of B	usiness/Inc	lustry	
and Ide	Elementary/Secondery (0-12)	Cotlege (1-4or 5+			during most of world)					
	11		Accou	inting Su				overnment		
Be Be	17. Father's Neme (First, Middle, Las.	,			18. Mother's Nem	e D. Ken		ne)		
To To	Francis Norber									
110	19e. Informent's Neme Tolationship (Type, Print) Lisa E. Føwler/Daughter 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 3300 Prairie Avenue, Brookfield, Illinois 60513									
Day of the last	20a, Method of Disposition		20b. Place of Dispo		1	Date	20c. Location			
Pages or or or or	1 ☐ Burial XI Cremation 3	Removal from State	A cemetery, cre	metory or other pla		-08-200			Maryland	
Me.	4 Donation 5 Other (Speci 21 Signature of Further Service Lice	1//	Huntt Cr		1			011,	riar y rand	
any i	HUE	J1 201	ran"	The Hunti	ss of Facility Funeral	Home, 1	nc.			
mew	MARK G. BRO	HAWN MOO		P. O. Box	< 156, Wa	1dorf, M	laryland	206		
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ysician Tedical	Immediate Course /Final			11.15					Onset and Deetin	
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min min		p. 1051	ue to (or as a consecution of the consecution of th	EVEN (CA	1(1)(0)	MICOG	M	(SAT	
el-tra	Sequentially list conditions, if any, leading to immediate	D	ue to (or es a conse	quence of):			())7	SAFF		
o physician and as the burial-transit	cause. Enter Underlying Cause (Disease or trijury that initiated events	C	ue to (or es a consec	merce off.						
ed as the	resulting in death) Last		10 (Or 83 & CO1560	poerice org.						
attending for use as clan/Me	La sur Mayor	d								
od for	Pert It. Other significant conditions	contributing to death but	not resulting in the u	indertvina cause aix	ven in Pert t	23b. Did t	obacco una co	ntributa to	the cause of death?	
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i certificate has been si firector, page 2 should o Be Completed						101	es 2 No		Yes 2 No	
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o B	examiner?	Hospitet:	2 ☐ ER/Outpatier	nt 3 DOA Oth	ver _	ome 5 Resid		ner (Snecifi	4	
erald erald n: T	27. Menner of Death	28a. Dete of triury	28b. Time o			28d. Describe h			"	
e fun	1 Neturet 5 Pending 2 Accident investigation	(Month, Day)	(ear) Injury		Yes 2 No					
al Director: After to led in by the funeral Certification:	3 Sulcide 8 Could not be determined	200. Pleca of injury	- At home, ferm, str	reet, fectory, office				ber or Rura	Route Number,	
Ceri in	4 CI HOMIGIO	building, etc.	(Зреспу)			City or Tou	m, State)			
Funeral etely filled dical C	29e. Certifier 18 Certifying Pr	yeician: To the best of	my knowledge, deat	h occurred at the tir	me, date end place,	end due to the	ause(s) end m	anner as st	ated.	
where the formers of precions the this certificate he completely filled in by the funeral director, page medical Certification: To Be Com	one) 2 Medical Exal	miner: On the basis of ea end menner stete	d.	vestigation, in my o	opinion, deeth occur	red et the time, i	pare and place,	and due to	ine cause(s)	
Tothe	29b. Signature and title of certifier			29c. Licens	se number	10	29d. Dete signe	d (Month,	Day, Year)	
	1/10	-	71	()-	187	15/	MANCH	4.	2000	
	30. Neme and address of person who	completed cause of dea	th (Item 23a) (Type,	Print)	- 410 - 4				A POLETIC	
	K. WISOTOKY	(d) 120	70 Qu)	SAND	5-0785	. WAL	DOAF	Mo	1 2060	
State	31. Date filed (Month, Day, Year)	32. Registrer		. /	4					
Registrar	MAR 06	2000	we b	· pou	Kal					

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Description of the condition of the cond							Certi	ficate	of Death		Reg. No.			
February 24, 2000 4:15 a.m. February 24, 2000 6:05 a.m. February 24, 200			1. Decedent's Nem	ne (First, Middle, La	st)									
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Some Benefit Name Sea Sea	V.								4b. Clty, Town,				7125 22111	
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All	Fune	ral		Number 6. S	ex 7. /	x 7. Age (In yrs. last birthdey) If Under 1 Y								
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Specific conditions	Mar a-f st	ţo	Maryland	Prince G	enrae's		Capito	1 Hei	ahts				1 ☐ Yes ZX No	
Specific conditions	th the 28 24 28 24 28	je je	10e. Street and Nu	ımber				10f. Zip Co	de		10g. Citizen of			
Specific conditions	th wil	a	5009	Doppler S	treet			207	43		U.S.A.			
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Specific conditions	020 urs after al. or its	by Fu	3.7		1 ☐ Yes 2 ☐	No								
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The state of the s	215	ple				r 5+)	life. DC	NOT use r	etired)	WOIKING				
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Security	- C 8 0 F		Lucill	e Bruzzes	e (Daught			- 4-						
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Physician Middel Same Fine Fine Same Fine Fine Same Fine Fine Same Fine Fine	_		23a. Pert1. Enter	the diseese, or com	ligations that caus	ed the death	n. Do not enter	the mode o	dying, such as care	diac or respiretory	errest,		Approximate	
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State Stat	this by	-			1 LI Inpa			_	4 LI Nursin				(y)	
29a. Certifier (Check only one) 29b. Signeture end title of certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) ALI RAITIMIAN MD 7801 Old Branch AVE Clinton MD 20 735 State 31. Date filled (Month, Day, Year) 32. Registrer's Signature	Ing I	on	1 Natural	5 Pending		Day Year)				Zou. Describ	B flow injury occu	1160		
29a. Certifier (Check only one) 29b. Signeture end title of certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) ALI RAITIMIAN MD 7801 Old Branch AVE Clinton MD 20 735 State 31. Date filled (Month, Day, Year) 32. Registrer's Signature	SIC tend tor:	cat		_						OPA Location	(Ctreat and Num	har or Bur	al Pauta Number	
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Registrar

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APPLICATE AND A PROPERTY.

Service Services

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death 7:20 Am Month Year **Physician** MARY FORR FEBRUARY-2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** and REHAB. CLINTON OAKS NSG. CENTER PRINCE GEORGE'S If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Dete of Birth (Month, Dey, Year) **Funeral** Months Devs Hours 579-26-0657 1 M 200F 75 Director Dec 19, 1924 Washington DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 ☐ Yes 2 No Director 28a-f P.G. Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 3503 #A Terrace Drive 20746 United States or Berns 23a Funeral 12. Wes Decedent Ever in U,S.
Armed Forces 7.

1 Yes 2 2 Ho
If Yes, Give
Yeer or Detes: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0020 à White 3 Widowed 4 Divorced Completed 16a. Decedent's Usuet Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Sales Associate Woodies Company 12 important of Health and Mental Hy Important: If Ihm 27 is marked off 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Edward Lee Farr Martha Helen Steele 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Melinda F. Buck (SISTER) 14100 School Lane, Upper Marlboro, Maryland 20772 20e. Method of Disposition

1 Surial 2 Cremetion 3 Removel from Stete 20b. Place of Disposition (Name of Feb 28, 2000) 20c. Location - City or Town, State 4 □ Donetion 5 □ Other (Specify) Epiphany Episcopal Cemetery Forestville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Ferry Road, Clinton, Maryland 20735 23a Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart feilure. List only one ceuse on each line. Onset and Deeth **Physician** /Medical Immediate Cause (Finet diseese or condition resulting in deeth) Examiner Examiner attending physicien and for use es the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Last Due to (or as e consequence of): Box 68760. Physician/Medicai Due to (or es a consequence of): Pert tl. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contributa to the cause of death? P.0. Yes 2 No 3 Probably 4 Unknown signed I Records, by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician:
white 24 hours after death.

To the Funeral Director: After this certified completely filled in by the funeral director, Be 25. Wes cese referred to medicet examiner? 26. Place of Death (Check only one) SONO Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. Injury et Work? Netural 5 Pending 1 ☐ Yes 2 ☐ No investigetion 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier edical (Check only one) 29b. Signeture and und 290 License number 29d. Date signed Month, Day, Year) ddress of person who completed ceuse of death (Item 23a) (Type, Print) 7016K Dete filed (Month, Dey, 32. Registrer's Signeture State **FEB 2 8 2000** Registrar

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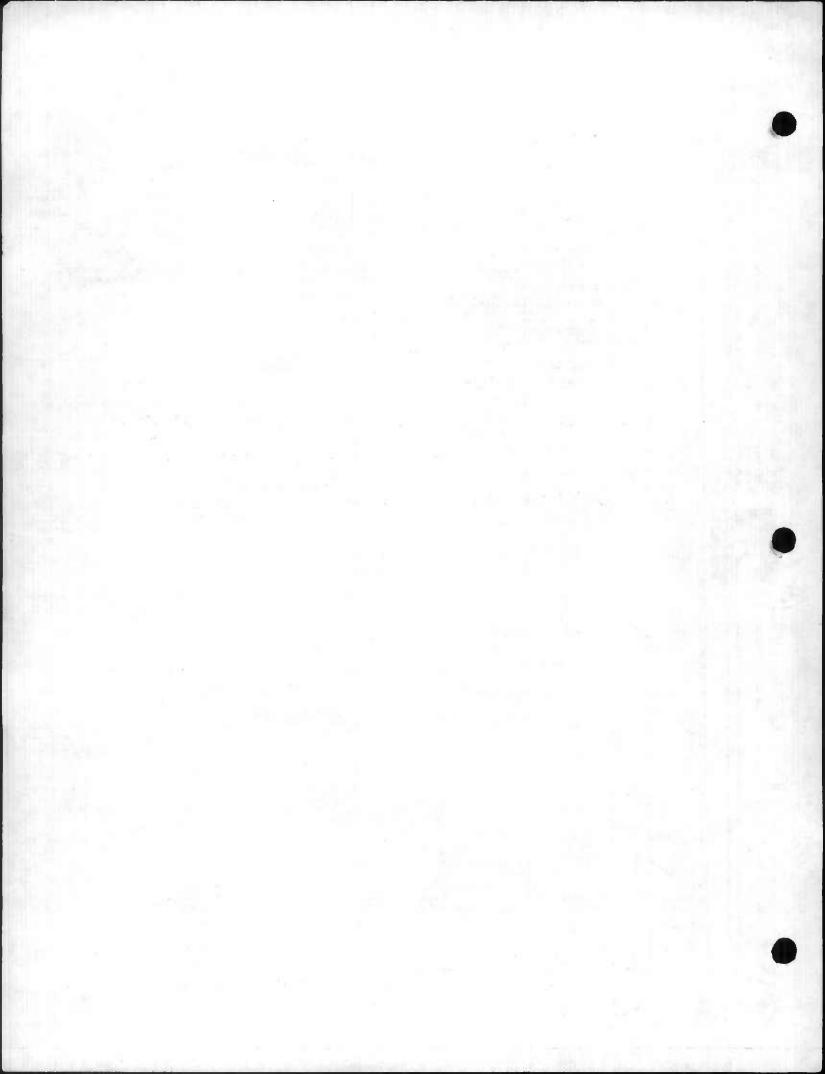
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			State of	f Maryland		artment of H			giene Reg. No.	0 08	3723	
	Physician /Medical	Decedent's Nama (First, Middle	, Last) MAR	Y FRA	NCES	FANNII	V	2. Date of De Month March	oth Day 200		Tima of Death	
N	Examiner	4a Facility Name (If not institution 402 East Balt				4	ib. City, Town, o Taneyt	or Location of Death	,	of Deeth 11 Cou	nty	
	Funeral Director	5. Social Security Number 214–14–7137	6. Sex 1 ☐ M 2 🗹 F	7. Aga (In yrs. les	st birthdey) 18 Yrs.	If Under 1 Yaar Months Days	If Under 24 H Hours M		th Year) 9, 1921	9. Birthplace Country) Virgin	(State or Foreign	
	D .	Usuel Residence of Decedent 10a. State 10b. County		10c City	Town or Lo	ocation				104 6	inside City Limits	
	Maryle Maryle Fred also	, , , , , , , , , , , , , , , , , , , ,	oll Count		Town of Lo		ytown				Yes 2□No	
	3a or 28 It be not	10e. Street and Number 402 East Balti	imore Stre	eet		10f. Zip Code	217	87	10g. Citizen of W United		5	
020	n 72 hours after deeth with the Maryland "natural", or items 23s or 28s-f show accel Examiner must be notified leted by Funeral Director	11. Marital Status 1 Navar Marriad 2 Marri 3 Widowed 4 Divorced	Armed Fo	2 🔼 No /e		Was Decedent of H If Yes, specify Cubs	ispanic Origin? an, Mexican, Pu Specify:	(Specify Yas or No arto Rican, etc.)	Biack	- American fr k, Whita, atc. White		
21215-0020	c • a =	15. Decedant (Specify only highes Etementery/Secondary (0-12)		-4or 5+)	(Giva	dant's Usuel Occup kind of work done o DO NOT use retired nemaker	ation during most of v f)	vorking	16b. Kind of Business/Industry OWN home			
land 2	Maryland nd 2 should be file lith and Mental Hy 27 is marked other r traumatic avent To Be (1.2 17. Father's Neme (First, Middle, Last) William S. Calageras 18. Mother's Name (First, Middle, Meiden Sumeme) Rose Anna Harmon										
		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code Kathleen M. Fannin-Balmer/daughter 1476 Harney Road Littlestown, PA 17340										
a	Peges 1 e nent of Hea int: If Rem iry or othe	20a. Method of Disposition 1										
Balt	pemit. Departm Importat any inju	21. Signature of Funeral Service I	Licensea 7	MO1		2. Name and Addres B6 East B					21787	
	Physician	23a. Part1. Entar tha disaasa, or shock, or heart failure. List	complications that conly one ceuse on e	ausad the deeth. ach line.	Do not ent	ter the mode of dyln	g, such as card	liac or respiretory e	rrest,	tnte	proximete erval Between sat end Death	
	/Medical Examiner	Immedieta Cause (Final disease or condition resulting in deeth) e. CONGESTIVE HEART FAILURE YEARS										
		Due to (or es a consequence ot): RENAL FAILURE 3 YEARS										
ó	ete be executed hysician and the burial-transit	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury										
× 68760,	eath certificate be executed attending physician and for use as the buriel-transit clan/Medical Examir	that initialed events rasulting in death) Lest Due to (or as a consequence of): d.										
Box	hat the death certific d by the attending p leteched for use as Physician/Me	Pert II. Other significant conditio	23b. Dld	tobacco use con	tributa to the	cause of death?						
P.O.	that the red by th detech		eer significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.							3 Probabl	y 4 Unknown	
cords	Physician: The law requires that the death certific this certificate has been signed by the attending praid director, page 2 should be deteched for use as rail director, page 2 should be deteched for use as: To Be Completed by Physician/Mee								en autopsy ormed?	avallab	autopsy tindings ble prior to ation of causa th?	
E E	The lay							10	Yes 2 No	1 ☐ Ye	es 2 No	
/ita	certificate rector, pag	25. Was cese referred to medical examiner?				l ou		Death (Check only	one)			
Division of Vital Records,	To the Hospital or Attending Physicien: The law within 24 water death within 24 water death of the Funeral Director. After this certificate hes completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	1 Yes 2 No 27. Manner of Death 12 Neturel 5 Pendin 2 Accident investig	28e. Date (Moni		R/Outpatier 28b. Time o Injury	f 28c. Injur Wor	4 LI MUISIN	28d. Describe	dence 6 Other			
Divis	tal or Attanding P rs after death. al Director: After t led in by the funera Certification:	2 Action 2 Action 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28f. Location City or City or 28f. Location 28f. Locatio								er or Rural Ro	uta Number,	
	To the Hospital or within 24 hours after To the Funeral Direction of the Completely filled in Medical Cert		g Physician: To the Examiner: On the ba and man									
	within Com	29b. Signatura and title of certifier	- Linte	Jecun 1	m).	29c. Licens			3/2	(Month, Dey,	Year)	
		30. Name and address of person with LIAM R	L LINTHI	cum, m	1.		DES DR	NE, TAN	EYTOWN	, m)	2 1787	
	State Registrar	31. Date filed (Month, Day, Yeer) MAR 0	3 2000 32. R	legistrar's Signetu		b. Los	rial					

D. Spain

CHARLES FURLONG		State of Marylan		artment of		nd Mental H	U	0 0872	l,	
PORLANG	1. Decedent's Name (First, Middle, Last)			timouto o	Dodin	2. Date of D	Reg. No.	3. Time of De	ath	
Physician	CHARLES EDGAR	FURLONG				Month FEBRU	JARY 25,2	Year 2000 8:32P.M	JI	
/Medical Examiner	4a Facility Name (If not institution, give s				4b. City, Tow	n, or Location of De			1.	
LAdillitie	SHOCK TRAUMA CENTE	ER			BALTI	ALTIMORE				
Funeral	Social Security Number 6. Sax		last birthday)	If Under 1 Yea						
Director	218-32-7885 Usual Residence of Decedant	M 2□ F 62	Yrs.	Months Day	s Hours	Min. (Month, L June		Maryland Maryland		
darytan f show led at	10a. State 10b. County Maryland Harfo		ly, Town or Lo	Forest I	#i11	10d. Inside City L 1 ☐ Yes 2				
or 28a-f be notifie Directo	10e. Street and Number	Lu		101. Zip Code			10g. Citizen of V	What Country?		
o all D	1712 K Landmark Dr	ive			050			USA		
ther death v r heme 23s siner.must Funeral		2. Was Decedent Ever in U	,S. 13.			n? (Specify Yes or N Puerto Rican, etc.)	lo- 14. Rac	ce - American Indian,		
5-0020 72 hours atternatural; or its steal Examina	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 12 Yes 2 No If Yes, Give Year or Dates:1963		If Yes, specify Cu 1 ☐ Yes 21K] No		Puerto Rican, etc.)	o Rican, etc.) Black, White, etc. Specify: White			
ted fath to be	15. Decedent's Educ	cation		dent's Usual Occ			16b. Kind of Business/Industry			
within and the Men	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work don DO NOT use retii .neer	e auring most o red)	or working	Mechanical			
and 2 ontal Hygined and other cevent, I	17. Father's Name (First, Middle, Last)				18. Mother	s Name (First, Midd	me (First, Middle, Maiden Sumame)			
And De Mand De	Charles Edward	Furlong			Doro	thy (n	mn) So	cales		
ary shout and Me	19a. Informant's Neme/Relationship (Typ	oe, Print)	19b. Mailie	ng Address (Street	et and Number	ber, City or Town,	r, City or Town, State, Zip Code)			
N PERS	Patricia A. Furlon	g - Wife	1712	K Landma	ark Dr.	21050				
OTO Ports of Table	20a. Method of Disposition		Place of Dispo	osition (Name of matory or other p	lace)	Date	20c. Location -	City or Town, State		
timore, L. Pages 1 ar tment of Hea tant: if Nem. fury or othe	1 ☐ Buriai 2 ② Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	A STATE OF THE STA	Service (27.5	2/29/00	Towson	, Maryland		
and	21. Signature Funeral Service License			2. Name and Add		_,_,_,		2		
m sales	N MANUER	m - 0 1				Home, P.A				
	23a. Part1. Enter the disease, or complications, or heart failure. List only on	cations half bused the deat	h. Do not ent	17 Cokes	sbury R	d., Abing	don, MD	21009 Approximate		
Obvoicion	shock, or heart failure. List only on	e cause on each line.						Intarval Between Onset and Dea		
Physician // // // // // // // // // // // // //	Immediate Cause (Final	11. 20. 0								
Examiner	disease or condition resulting in death)	MULTIPLE S			T WOU	Since		1 100		
- i		Due to (c	or as a consec	quence of):						
60, to executed sician and burlatransit	C b							1		
60, be exectted ician and burial-transit	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	Due to (d	or as a consec	quence or):						
a gigi & Q	Cause (Disease or injury that initiated events	D to								
m = 22 =	resulting in death) Last	Due to (o	r as a conseq	juence of):						
P.O. BOX 68 at the death certifica by the attending pheteched for use as the Physician/Med	d									
Clar			-10-10-10-1			1				
O # ## %	Part II. Other aignificant conditions con	ributing to death but not res			entribute to the cause of d					
						11	Yes 21 No	3 Probably 4 □ Un	Known	
II RECOIDS, P The law requires that The law requires that tale has been signed to page 2 should be det Completed by Pi						24a. We	es an autopsy formed?	24b. Were autopsy tind available prior to completion of caus of deeth?		
Thas has							/	/		
= = = = 0	25 W						Yes 2□No	1 Yes 2□ No	,	
	25. Was casa referred to medical examiner?	ospital:		C	Whor	of Deeth (Check only				
Physical distriction of the second of the se	1 ☐ Yes 2 ☐ No	1 ☐ Inpatient 2 ☐ 28a. Date of Injury	ER/Outpatier 28b. Time of	IL SCI DON	4 LI NUIS	sing Home 5 Re	sidence 6 UOth e how injury occur		-	
After fune	1 □Natural 5 □ Pending	(Month, Day Year)	Injury	W	ork?			SHOT BYP	OUL	
Attending or death. ector: Afte by the fune tiffication	3 Suicide 6 Could not be	2-25-00	16:35					ber or Rural Route Number		
- F555 E	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	y)	oor, ractory, unic		City or T	own, State)			
Filling C	29e, Certifier 1 Certifying Phys	Howe		nonumed at the	time data and			Dr. Us rear	COM	
he Hospi in 24 hou he Funer pletely fill edical		cian: To the best of my kno er: On the basis of examina and menner steted.								
To the Hospital of within 24 hours of To the Funeral Discompletely filled is ompletely filled in Medical Cel	29b. Signatura and title of certifier	and market stated.		29c. Lice	nse number		29d. Date signe	ed (Month, Day, Year)		
8 4 8 4	1100 - A	Daile								
	mayor Jone	WHU !	00-1 7		.C.M.E.		FEBRUAR	Y 26,2000		
541	30. Neme and address of person who con	npiered cause of death (Item			Street	Raltima	ma Massa	land 21201		
	21 Date Had West Day Va.	January W		TT LEIHI	Street	, parting	re, mary	TOIKI ZIZUI		

FEB 2 9 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure Ail Copies Are Legible. Amended Items 8 & 10c, 3/2/00 State of Maryland / Department of Health and Mental Hygiene Per F.D., Carroll County, wjl Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth FARQUHARSON **Physician** 29, 8000 WILLIAM FERRUARY 8:05 PM /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Deeth Examiner Northwest Hospital Center Randallstown Baltimore If Under 24 Hrs. A prese Birth 9 1 909 9. Birthplece (State or Foreign Country) If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) 90 yrs. **Funeral** Days 1♥M 2□F Months Hours 164-03-4357 Yrs. 1999 Mass. **Director** Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23s or 28s-f show Md Carroll Sykesvillle Sykesville 1 X Yes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7200 Third Avenue 21784 USA Pages 1 and 2 should be filed within 72 hours after death in nent of Health and Mental Hygiena.

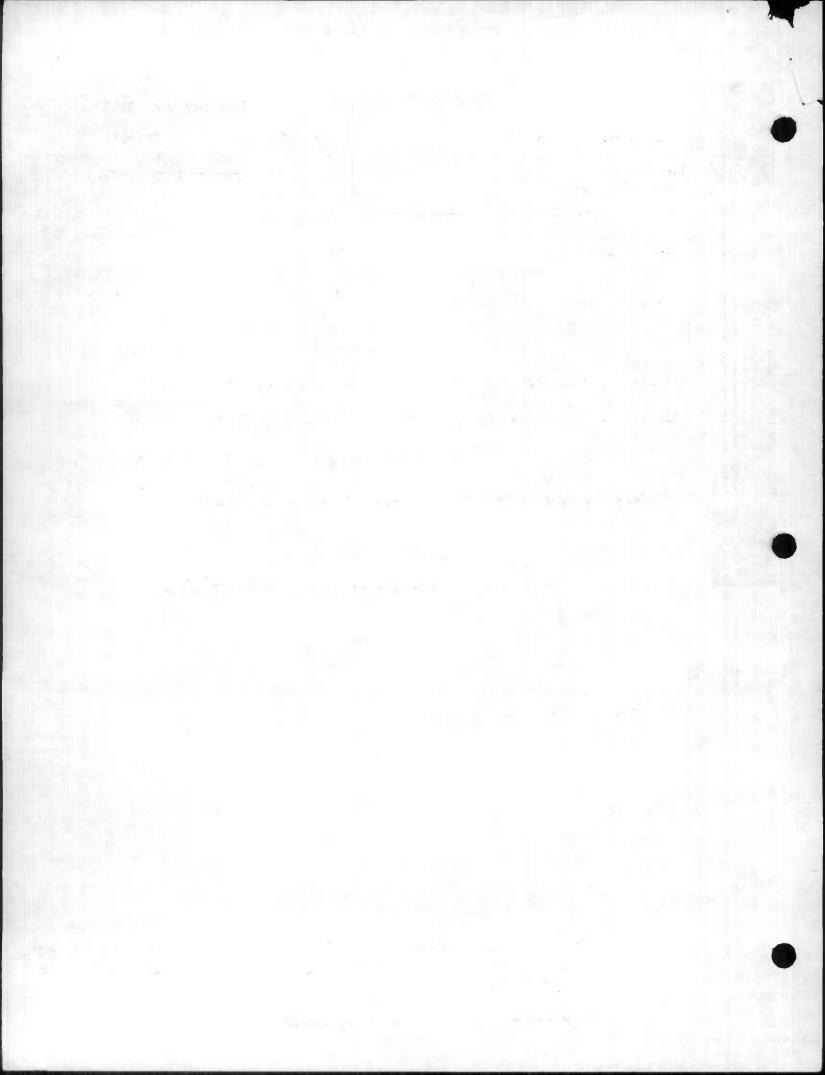
ant: If item 27 is marked other than "naturel", or Items 23, any or other traumatic event, the Wadical Examine must Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ ZNo If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Maritel Status Black, White, etc. 1 □ Never Married 2 □ Merrled Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Buainess/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) vice president insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) William C. Farquharson Mary K. Ross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) William R. Farquharson (son) 4922 Althea Dr., Annondale, VA 22003 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 X Cremetion 3 ☐ Removal from Stete permit. Page Department of Important: If any Injury or All County Cremation 3-6-2000 Sykesville, Md. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funerel Service Licensee P.O. Box 195 Sykesville, Md.

23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. P.O. Box 195 Sykesville, Md 21784 Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical SEPSIS **Examiner** STAPHYLOCOCCUS ARTHRITTS Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): attending pl signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of degth? Hyponationing 1 Yes 2 No 3 Probably Unknown þ 24a. Was an autopsy performed? 24b. Were autopsy findinga available prior to Completed completion of cause of death? certificata has b 1 Yes 2 DNo 1 ☐ Yea 2 ☐ No or Attending Physicien: after death. Director: After this certifica 25. Was cese referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospitel: To 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA funeral 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Sulcide Location (Street and Number or Rural Route Number, City or Town, Stete) 5 4 Homicide • Funeral Di letaly filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Man set Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title el D44105 MD 21133 30. Name and address of person 175

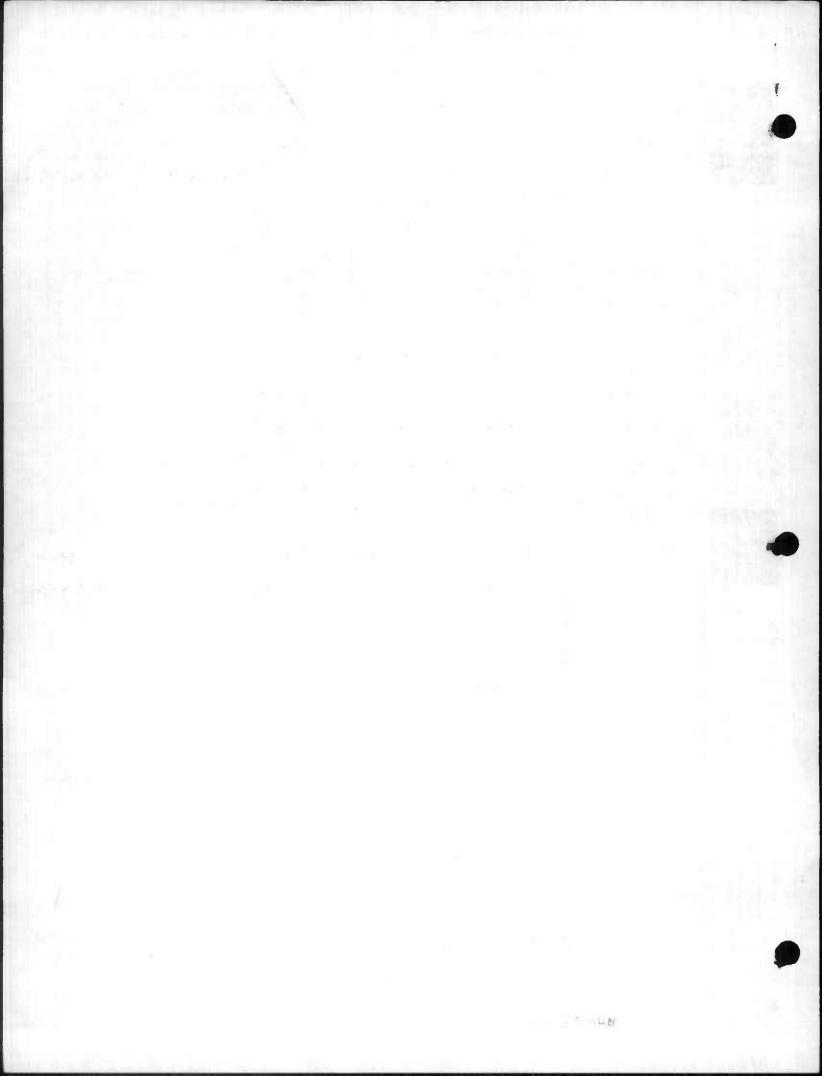
State Registrar th, Day, Year)

MAR 0 2 2000

32. Registrar's Signeture

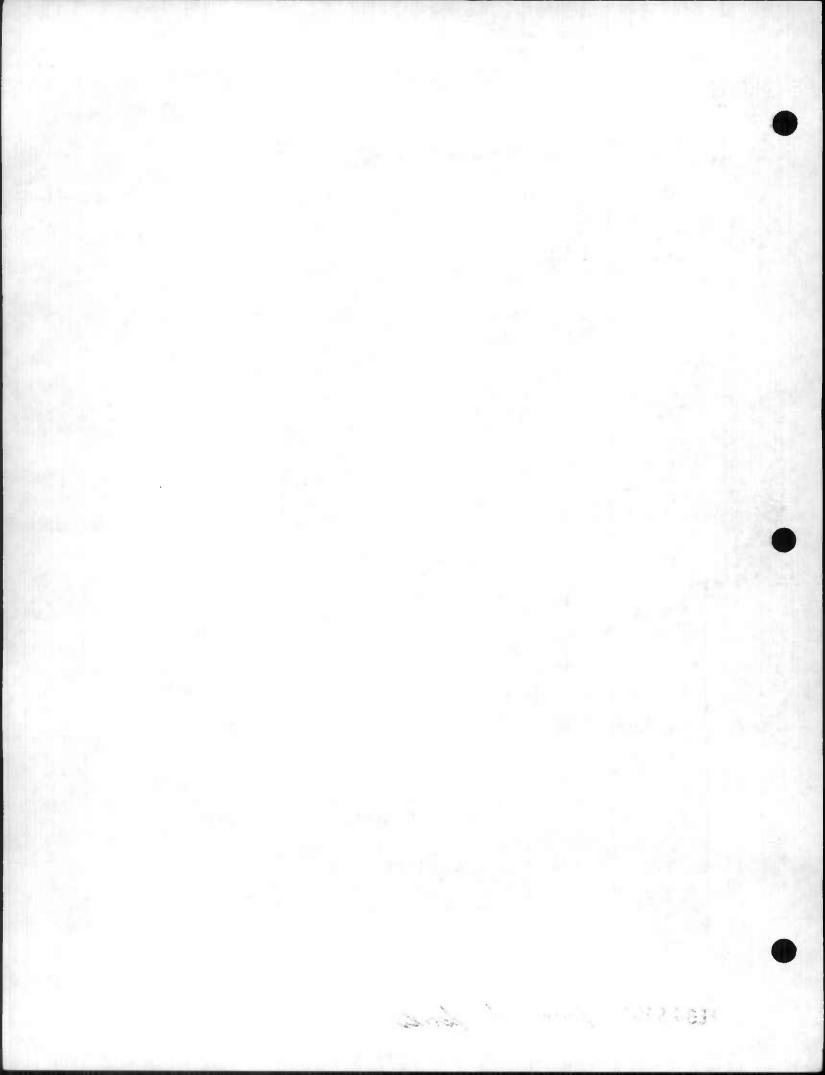


						Ce	rtificat	e of	Death		R	eg. No.	0	0120	
Dhari	1	1. Decedent's Neme (First, Mid	die, Last)							2. Dete	e of Deet	h		Time of Death	
Physic /Med		Carolyn	E. A.	Gr	eene					Febr		Dey 25, 2	000 08	335 AM	
Exami		4a. Fecility Neme (If not Instituti	on, give street end	number)					4b. City, Tow	m, or Location o		4c. County			
		Heron Point							Chester	ctown		Kent	County		
Funeral		5. Social Security Number	6. Sex		(In yrs. last t	pirthdey)	If Under		If Under 2 Hours	4 Hrs. 8. Dete	of Birth	Voasl	9. Birthplace	(Stete or Foreign	
Director	П	221-30-5210 Usuel Residence of Decedent	1□ M 2ŪX	F	87	Yrs.	Months	Deys	nours	Sep.	13,	1912	Steuben	ville,	
and		10e. Stete 10b. Count	у		10c. City, To	wn or Lo	cation				10d. Inside City Limi				
Vany Feb	0	MD Kent			Cheste		-					1 ☐ Yes 27 No			
15 28 th	Director	10e. Street end Number			Ollegte	10f. Zip Code					11	10g. Citizen of Whet Country?			
With or			22/			21620							Triot Country		
eath R 23	era	Heron Point, A		Decedent F	Ever in U.S.	13				In? (Specify Yes		JSA 14 Bec	a - American In	dlan	
d within 72 hours effer death with the Maryland piene. r then "natural", or flems 23s or 28s-4 show the Modical Examination must be notified as	Funeral	1 ☐ Never Married 2 ☐ Ma	Armed	d Forces? es 2 N			If Yes, spe	cify Cub	an, Mexican,	Puerto Rican, e	rtc.)		ck, White, etc.		
ers e	by	3 Widowed 4 □ Divorce	If Yes	Give A			1 🗆 Yes	2 No	Specify:	Specify:		Specify	White		
2 hou		15. Decede	nt's Education		16	16a. Decedent's Usuel Occupation					16b. Kind of Bu	usiness/Industr	1		
In 72	Completed	(Specify only high	est grade complet			(Give kind of work done during mos life. DO NOT use retired)			during most			TOD. TAILS OF D	uon resar in rousti		
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al Hygin other		17. Fether's Neme (First, Middle		12		nome	anake.	<u></u>	18. Mother	's Name (First.	Middle, N	Own Home			
should be and Mental marked or umatic eve	o Be	Hans Anderson							F1	1 .1 37					
should by and Menta	70	19e. Informent's Neme/Reletion	ehin (Tyne Print)		16	ab Maltir	na Address	/Strans		beth Ne	_		State Zin Cod	01	
U 6										t end Number or Rural Route Number, City of			3(6(6, ZIP COO	6)	
of Health item 27 i		Martha G. Phil 20e Method of Disposition	lips-dau	ghter	20h Piece	of Dispo	SZ-C11	ty H	wy. B,	Rio, W		3960	City or Town,	State	
or o		1 XBurial 2 ☐ Cremation					ce) Ceme								
permit. Peges 1 Department of H Important: If ite any Injury or ot once.		4 □ Donation 5 □ Other (_	01d S					1 3/2/2	000	Middlet	town, D	Е	
Depar Impor any Ir		21. Signeture of Funeral Service	Licensee	, (ss of Fecility		7 77				
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		Frank C. M 23e. Pert1. Enter the disease, c shock, or heert feilure. Lis	r complications th	et caused	the deeth. Do	not ent	er the mod	le of dyl	ng, such es c	ardiec or respire	etory erre	est,	E 1972	roximete rval Between	
Physician			,	D11 00011 III.	0.								Ons	et and Deeth	
/Medical		Immediate Cause (Final	0	DAIG	ECTI	12	40	20-	TCO	ILURE				1400	
Examiner		disease or condition resulting in death)	e		Due to (or as			110	1 14	ILUCE				year	
	je.	disease or condition resulting in death) e. CONGESTIVE HEART FAILURE Due to (or as e consequenca of): SEVERE ADRTIC STENOSIS >2 years													
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thet the death led by the etter detached for u	Physician/	Petri. Other significant condit	ons continuting t	o death bu	t not resulting	in the u	nderrying c	euse gr	ven in Pert I.	23				cause of death'	
es thet	V										1 🗆 Ye	a 2 No	3 Probably	4 Unknow	
The law requires that the death ate has been signed by the etter page 2 should be detached for the contract of	d by									246	Was a	n eutopsy	24b. Were a	utopsy findings	
v require	ete										perform		aveilebl	e prior to tion of cause	
has has	Completed												of deeth	17	
	S										1 ☐ Ye	s 2 No	1 ☐ Yes	30 No	
Attending Physicien: The releath. sctor: After this certificate by the funeral director, pages	Be	25. Wes case referred to medic exeminer?	al						28. Plece o	of Deeth (Check	only on	θ)			
5 00	2	1 ☐ Yes 2 No	Hospitel: 1	☐ Inpatier	nt 2 ER/C	Outpetier	nt 3 DC	OA Oth	ner: 4 Nurs	sing Home 5	Reside	nce 6 Oth	er (Specify)		
g Ph ter thi		27. Manner of Deeth 1 Neturel 5 ☐ Pend		ete of Injury fonth, Dey	Year) 28b	Time of	f 2	8c. Inju	ry et	28d. De:	scribe ho	w injury occur	red		
ath.	atic		igetion (**	normi, Doy	7 0477	nijury	M		Yes 2□N	0					
Afte or de by th	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deten	nined 286. Pl	ece of Inju	ry - At home,	farm, str	eet, factory	, office					er or Rural Rou	ite Number,	
effer Direct	en	4 Dilomode	Di	uilding, etc.	. (Зреспу)					Cny	or Town	, State)			
To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After th completely filled in by the funeral		29e. Certifier 12 Certifyi	ng Physician: To	the best of	f my knowledg	je, deeth	occurred	et the ti	me, dete end	plece, and due	to the ce	ouse(s) and me	enner as steted		
P Fu	edical	(Check only 2 Medica one)	Examiner: On the	e basis of one	exeminetion e led.	nd/or In	vestigetion	, In my o	plnion, deeth	occurred et the	time, de	ete end piece,	and due to the	ceuse(s)	
Vithle Forth	Σ	29b. Signeture end title of cartifi	er .				290	. Licens	se number		25	d. Date signe	d (Month, Dey,	Year)	
- > - 0		1 Ha	NAHL	li-	mo)4	158	7		21	25/0	0	
		30 Name and address of account	who completed			\ (T			,	-			/		
		30. Neme end eddress of person						¥ ¥==	MD 0	1620					
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State of Maryland / Department of Health and Mental Hygiene 00 08727

an						Dealli	T = =	Reg. No.			
al	Decedent's Name (First, Middle, Joseph			Go1d	l		2. Date of De Month Februa	ry 22 2	Year 2000_	3. Tima of Deeth 9:00 PM	
	220-48-0863	lace	r) ige (In yrs. las 87	t birthdey) Yrs.	If Under 1 Year Months Days		8. Date of Bir	Mont	gome	tace (State or Foreign	
-	Usual Residence of Decedent		100 City	Four or Loc	ation				14	Od Incide City Limite	
	10a. State 10b. County		TOC. City,	Fown or Loc					10	0d. Inside City Limits 1 ☑ Yes 2 ☐ No	
	Maryland Montgo	nery			Beth	esda	2//			46	
	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?			
	7020 Braeburn P.	12. Was Deceden	4 Francis II C	12 141	1	817	manifu Van as Ne	United	State - Americ		
	11. Maritat Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces	?] No		Yes, specify Cub	Hispanic Origin? (S ban, Mexican, Puer Specify:	o Rican, etc.)	Biad Specify	ck, White,		
	15. Decedent's	Education		16e. Decede	ent's Usuai Occu	pation		16b. Kind of Bu	usiness/Inc	lustry	
	(Specify only highest s Elementery/Secondary (0-12)	College (1-4o	(5+)	(Give kind of work done life. DO NOT use retire		ne during most of working red)		Intern		nal	
	12	5+	.,	A	ttorney		Financ	e			
	17. Fether's Name (First, Middle, La Solomon	st)		Gold		18. Mother's New	ne (First, Middle	, Maiden Sumen L	ights	steen	
	19a. Informant's Name/Reletionship	(Type, Print)		19b. Mailing	Address (Stree	t end Number or R	ural Route Numb	er, City or Town,	Stete, Zip	Code)	
	Joan Gold / Daug	ghter				n Place,	Bethesd	a, MD	20817	7	
20b. Method of Disposition 1 Burial 2 XCremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Chesapeake Crematory Inc. 20c. Location Feb. 24 Belts											
Immediate Cause (Final disease or condition resulting in death) a. Respiratory Fallure Due to (or as a consequence of): Failure to thrive Sequentially list conditions, if any, leading to immediate course. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Cardio Artery Disease Due to (or as e consequence of): d. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco underlying cause given in Pert I.								tobacco usa co Yes 2 □ No		o the causs of death	
							24e. Was	an eutopsy ormed?	av	ere autopsy findings ailable prior to	
			h -						of	mpletion of ceuse death?	
1 Yes 2 No 1 Yes 2 No											
director, page 2 should fo Be Completed											
-	25. Was cese reterred to medicat examiner?	Hospitel:		(ear) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred							
	examiner? 1 Yes 25 No 27. Menner of Death 1 Natural 5 Pending	Hospitel: 1 inpai	jury 2	Bb. Time of		ury at ork?]Yes 2 ☐ No	28d. Describe	how injury occur	100		
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State of Maryland / Department of Health and Mental Hygiene 00 08728

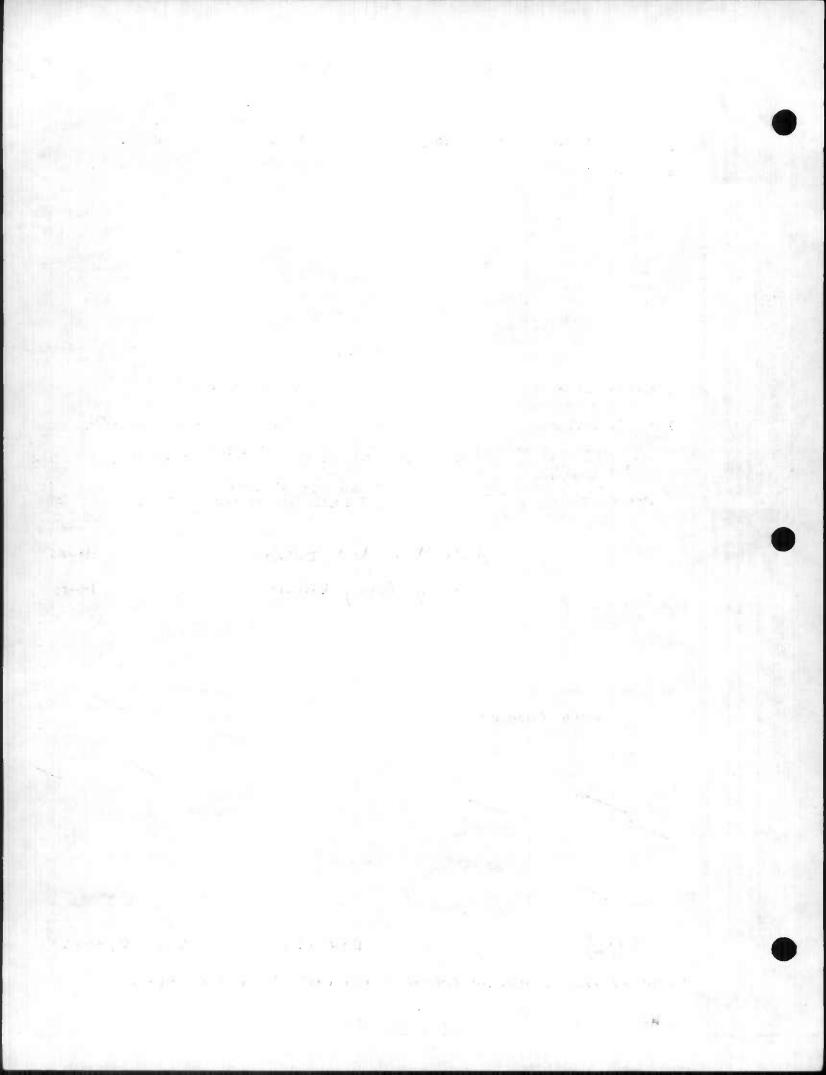
				Cei	rtificat	e of	Death			Reg. No.		00120
										3. Tima of Death		
Physician	Roseann Marie	Gaffnev							Month February	Day 24	2000	6:30 am
/Medical	4a Facility Name (If not institution,	- J	or)				4b. City. To		ocation of Deat			0.30 all
Examiner	3207 Orleans Ave											
			Aga (In yrs. la:	st hirthday)	If Under	r 1 Year	Fores			Princ		
Funeral Director	219-54-6032 Usual Residence of Decedent	1□M 2∏F	51	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, De March	l2, 1948	Mass	place (State or Foreign ntry) achusetts
1	10e. State 10b. County		10c. City,	Town or Lo	cation						1	10d. Inside City Limits
or thems 23s or 25s-1 show miner must be notified at 7 Funeral Director	Maryland Prince	George's		stvil	1e							1 ☐ Yes 2 🖾 No
Dire	10e. Street and Number				10f. Zip	Code				10g. Citizen of What Country?		
1 2	3207 Orleans Ave				207	747				U.S.A.		
by Funeral	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 ADivorced	12. Was Deceder Armed Force 1	s? No		Was Dece If Yas, spe 1 Yas	cify Cub	an, Mexica	n, Puarto	ecify Yas or No Rican, etc.)	Black, White Specify: Whi		
	15. Decedent's			16a. Deced	denl's Usu	el Occu	pation			16b. Kind of B	lusiness/In	dustry
Completed	(Specify only highest (Elementary/Secondary (0-12)	grade completed) College (1-4c	v 5.\	(Give	kind of wo DO NOT u	ork done se retire	during mos	it of work	ing			
mo	Lioinontary/occurroary (0-12)	4		Analy	st Co	mpu	ter P	rogra	ammer	Privat		
Be	17. Father's Neme (First, Middle, La		18. Mother's Name (First, Middle, Maiden Sumeme)									
ToB	Peter Michael Ga		Rose Marie Kurek									
-	19e. Informant's Neme/Relationship	-		19b. Maitir	ng Address	s (Street	end Numb	er or Rur	el Route Numb	er, City or Town	, Stete, Zip	Code)
unert of Health a lant: If Nem 27 Is jury or other tre	Donna M. Kahn - Sister 3207 Orleans Avenue, Forestville, Mary									rvlan	d 20747	
	20a. Method of Disposition	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	20b. Pla	ca of Dispo	sition (Ne	me o/			Date	20c. Location	-	
	1 M Burial 2 Cramation 3 Removal from State 4 Donation 5 Other (Specify) Commetery, cremetery or other place) Queen of Heaven Cemetery 03/03/00 Peters Tow										Town	ship, PA
9500	21. Signature of Furtheral Service of	Soften Carry	00	G	asch'	s F		l Hor	me, P.A	attsvil	1e. M	m 20781
hysician	23a. Part1. Enter the disease, or co shock, or heart failure. List or	mplications that caus	ad the death								1	Approximata Intervat Between
	snock, or near failure. List of	lly one ceuse on each	ı iine.								1	Onset and Death
al	Immediate Cause (Finel	Odanska										37
er	disease or condition resulting in death) Due to (or as a consequence of):											Years
5												
min	b. Chronic Alcoholism										Years	
al Examiner	Cause (Disease or Injury that initiated events Due to (or as a consequence of): resulting in death) Last											
Medical												
by Physician/	Part II. Other significant conditions	contributing to death	but not result	ting in tha u	nderlying o	ause gi	van in Part	1.	23b. Dld	tobacco uae co	ontribute t	o the causs of death?
y Phy		us							10	Yes 2⊠ No	3 Pro	bably 4 Unknown
Completed b									24a. Was	s an autopsy ormed?	av cc	Vera autopsy findings vailable prior to omplation of cause death?
Eo	THE RESERVE								10	Yas 2 No	1	☐ Yes 2☐ No
BeC	25. Was case referred to medical						26. Place	e of Deal	th (Check only	one)		
ToB	examiner? 1 Yes 2 No	Hospitel:	tient 2 🗆 E	R/Outpatier	nt 3 D	OA Ot	her:			idenca 6 □Ot	her (Sneci	ifu)
	27. Manner of Death 1 X Natural 5 Pending	28a. Dete of It (Month, I		28b. Time of Injury		28c. Inju	4.			how injury occu	-	,,
Certification:	2 Accident Investiget 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of	Injury - At hometc. (Specify)	ne, farm, str						(Street and Num iwn, State)	ber or Run	el Route Number,
edical Ce	(Check only 2 Medical Ex	Physician: To the bes	of axaminatio									
Medical Certification: 7	29b. Signatura and titla of other line.	and manner	Stated.		29	c. Lican	se number			29d. Date sign	ad (Month,	Day, Year)
9	1				Т	194	2.1			Fahrus	rs7 2/	2000
()			4 4	00-1 (7		7174.	21			Februa	Ly 24	, 2000
1	30. Name and address of person wh			- 377								
	Frank M. Kyan,				n_Roa	ad,	Suite	203	Ft. W	ashingt	on, M	ID 20744
State	31. Date filed (Month, Day, Year) FEB 2 8 2000	32. Hegis	strar's Signatu	i.e								
Registrar	4 FD N G C000	120	2		00 4							

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

			Cei	rtificate o	f Death		Reg. No.	JU	08729
	1. Decedent's Name (First, Middle, L	est)				2. Date of De Month	ath Day	Vaar	3. Time of Death
Physician /Medical	Merle J. Hall					March 2		Year	22:10
Examiner	4a Facility Neme (If not institution, g				4b. City, Town, or	Location of Deatl	4c. County	y of Death	
	Union Hospita	1 of Cecil Co	unty		Elkton		Cec	cil.	
Funeral Director	409-50-1997	4 TH ATE	yrs. last birthday) 2 Yrs.	If Under 1 Year Months Day		8. Dete of Bir (Month, Da Feb . 13	th, Year) 7, 1928	9. Birthp Coun Ten:	placa (State or Forei ntry) nessee
2 .	Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or Lo	antina					and to ide one time
death with the Maryland ms 23e or 28s-1 show crass to notified at neral Director	Maryland Ceci		Elkton	CallOff					1 ☐ Yes 2 ☐ P
th with the Ma 23s or 28s-fa 1st be notified al Director	10e. Street and Number 379 Bouchelle F	load		10f. Zip Code 2192			10g. Citizen of 1		
at, or its	11. Marital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		Was Decedent of if Yes, specify Cu	Hispanic Origin? (Suben, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	Ble	ce - Americ ck, White, by: White	etc.
ed within 72 hours yglene. Nor then "netural", It, the treaties Ex. Completed by	15. Decedent's (Specify only highest of	Education rade completed)	16a. Deced	dent's Usuel Occ	upation e during most of wor	rkina	16b. Kind of B	usiness/Inc	dustry
	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use reti	red)	9		1	1
Hygie Hygie M. E. E.	12		Ho	memaker	I as an area as				own home
should be flied within and Mental Hygiena. marked other then immatic event, the Mr. To Be Comp	17. Father's Name (First, Middle, Las					ne (First, Middle, ret Rob		ne)	
should be and Mental marked or umatic eve			461 14 "					Oct. T	Codel
	19e. Informent's Neme/Relationship				et end Number or Ru				
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiana. Important: If item 27 is marked other than any injury or other traumatic event, the language. To Be Comp	Larry G. Hall .		b. Plece of Dispo		ine, North	Date Date	20c. Location		
	1 🖾 Burial 2 🗆 Cremation 3 4 🗆 Donation 5 🗆 Other (Spec	Removal from Stete	cemetery, crem	netory or other p	list b	larsh 6,			Maryland
Departition of the control of the co	21. Signeture of Funeral Surface Up	nego de	metery	Crouch	ress of Fecility Funeral H oth Main S		North E	nat	2190
-	23a. Part1. Enter the disease, or co shock, or heart feilure. List on	nplications thet caused the d	leath. Do not ent	er the mode of d	ith Main S ying, such es cardied	or respiretory e	morth Ea	ast,	Approximete
Physician	Shock, or neer religie. Est on	y one cause on each line.						1	Intervel Between Onset and Death
/Medical	Immediate Cause (Finel disease or condition resulting in death) a. Acute Myocardial Infarction								Hours
Examiner	resulting in death)	a. Due t	o (or as e consec	uence of):	Thims	214		1	Cioning
- i			NOTY 1	A_+	Disease				Years
certificate be associted nding physicien and use as the buriel-transit n/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury thet initiated events resulting in death) Last	Due t	o (or as a conseq	uence of): /					
death death ad for u	Pert II. Other algnificant conditions	contributing to death but not	resulting in the u	nderlying cause	given in Pert I.	23b. Dld	tobacco use co	entribute to	o the cause of deat
as that the death ce gned by the attendi be detached for use by Physician/I	Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did to							3 100	bebly 4 Unkno
aw requires to see a see						24a. Wes	an autopsy ormed?	av	ere eutopsy findings alleble prior to impletion of cause death?
yelclen: The law is certificate has be director, page 2 a To Be Compli						10	Yes 2 No	1[Yes 20 No
artifica octor, Be C	25. Was case referred to medical				26. Place of Dec	eth (Check only	one)		
Physicien: this certific ral director, TO Be	examiner? 1 Yes 2 No	Hospitel: 1 Inpatient	2 ER/Outpatien	I 3 DOA	Other: 4 Nursing H	lome 5 ☐ Resi	dence 8 Oth	her (Specil	(y)
To the Hospital or Attending Physical Within 24 hours after deeth. To the Funeral Director: After this completely filled in by the funeral di Medical Certification: Tc	27. Manner of Death 1 Anatural 5 Pending 2 Accident investigati		28b. Time of Injury	W	iury et /ork? Yes 2 No	28d. Describe	how injury occur	rred	
Direction by the control of in by the control of th	3 Suicide 6 Could not determine		At home, ferm, streecify)	eet, factory, offic	9	28f. Location (City or To		ber or Rura	al Route Number,
To the Hospital or Attending P within 24 hours after deeth. To the Funeral Director: After completely filled in by the funer Medical Certification:	29a. Certifier 1 Certifying P (Check only one) 2 Medical Ext	hysician: To the best of my miner: On the basis of examend manner steted.	knowledge, deeth inetion end/or Inv	occurred et the vestigation, in my	time, date and place opinion, deeth occu	e, and due to the arred at the time,	ceuse(s) and modate and place,	enner as s and due to	stated. the cause(s)
Vithin Comple	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signe	ed (Month,	Day, Year)
->-0	MI			Doc	47711		March	3,6	Dool
10	30. Name and address of parson who	completed cause of death f	Item 22a) (Time	Print)			, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-	
/ 0	DAVID GAR-EL	3 MALLDIN A			AM THA	th can D	2190	1	
State	31. Date filed (Month, Day, Year)	32. Registrar's Si	-						
Registrar	MAR 0 6 2000	Auto	4 1	na Val					

DHMH 16 Rev 6/95



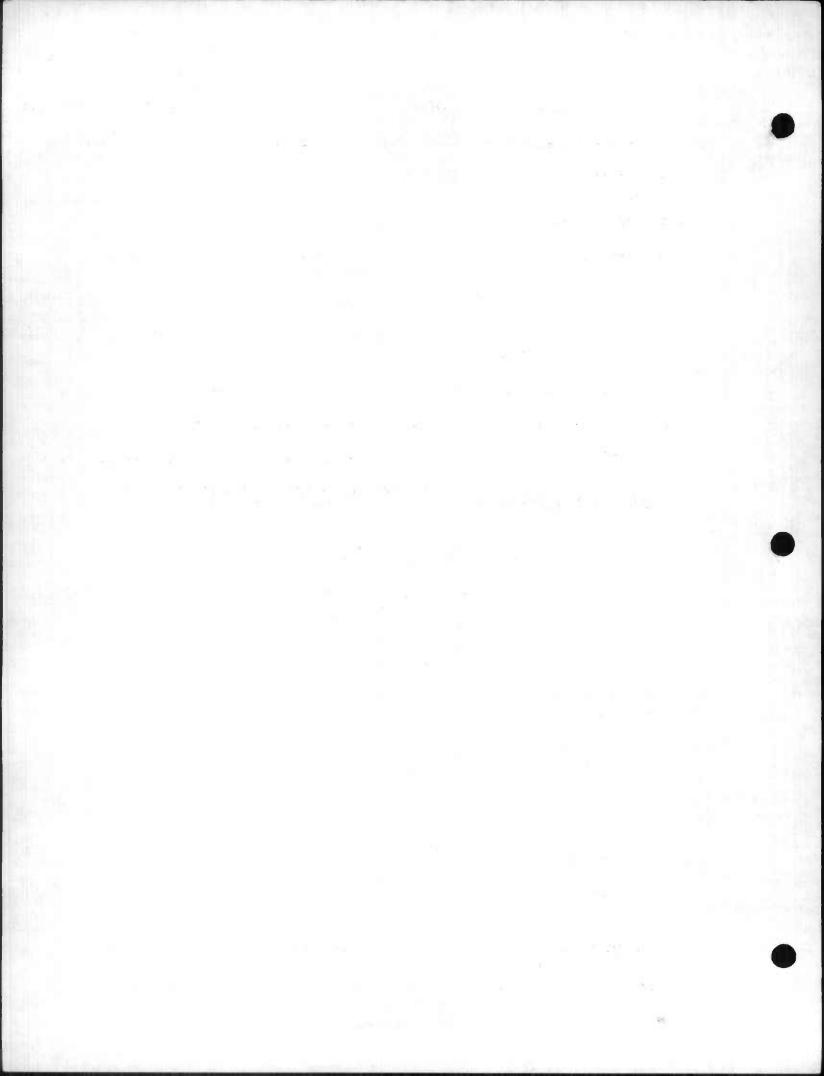
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Dey **Physician** 5, 7:30 a.m. Rozanne Barrett Hostetter 2000 March /Medical 4a. Fecility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Desth Examiner Calvert Manor Healthcare Center Rising Sun Cecil 8. Dete of Birth (Month, Dex. Year) Sept. 25,1924 If Under 1 Year Months Deys If Under 24 Hrs. Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1□ M 2♥ F 75 216-24-1637 Director Maryland Usual Residence of Decedent filed within 72 hours after death with the Meryland Hyglene. Wher than "natural", or Herra 23a or 28a-4 show 10e. Stete 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Cecil Colora Directo Maryland 10e. Street end Number 10f. Zin Code 10g. Citizen of What Country? 876 Firetower Road 21917 U.S.A. Funerai 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11. Meritel Stetus Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Detes: 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: þ White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Weatherhorse Antiques Coilege (1-4or 5+) Two Years Elementery/Secondery (0-12) Self-Employed Antique Dealer Colora, Maryland permit. Peges 1 and 2 should be life Department of Heelth and Mental Hy Important: if item 27 is marked oth any linjury or other traumatic event 2008. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Paul Alexander Barrett Mildred Mae Davis 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21917 Paula H. Gilley (Daughter) 35 Oak Street, Colora, Maryland 20b. Plece of Disposition (Neme of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 XX remetion 3 ☐ Removei from Stete R.A. Ferris & Co., Inc. 3/6/00 West Chester, Pennsylvania 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerei Service Licensee 22. Neme end Address of Facility Lee A. Patterson & Son Funeral Home, P.A. NONCEP M. TOURS 10%. Perryville, Maryland 21903-0766 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory srrest, shock, or heart feilure. List only one cause on each line. **Physician** immediete Cause (Finel disease or condition resulting in deeth) /Medical Dementia, mult. infarct ~6 years **Examiner** Due to (or es e consequenca of) Examiner mlyeur sura lowing Dysfunction ettending physician and for use as the burial-transit Sequentielly list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last Due to (or as e consequence of): Box 68760 the deeth certificate be Physician/Medicai Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? the signed by 1 Yes 2 No 3 Probably 4 Unknown Hypertension Division of Vital Records, þ 24b. Were autopsy findings avsilable prior to completion of cause of death? Completed 24e. Wes en autopsy performed? certificate has 1 Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Yes 2 XNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how Injury occurred Certification: 28c. Injury at Work? After t 1 Meturel 5 Pending investigation death. 1 Yes 2 No or Attandl efter death Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled la 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the beste of examination end/or investigation, in my opinion, deeth occurred at the time, dete end plece, and due to the ceuse(s) and menner steted. edicai 29e. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 12000 D44373 mp 30. Neme end address of person was completed cause of deeth (Item 23e) (Type, Print) 2 Joseph Weidner, Jr., M.D., 101 Colonial Way, Rising Sun, Maryland 31. Dete filed (Month, Dey, Year)

State Registrar

MAR 0 6 2000

32. Registrer's Signeture



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

08731.

		Certificate of Death	Reg. No.								
Physicia /Medica	PIAURITA AUNES GURDUN NAKLET		2. Dete of Deeth Month Dey FEBRUARY	7 2000 10:45 A							
Examine	4e Facility Neme (If not institution, give street end number) Doctors' Community Hospital	Lanham	Pri	nce George's							
Funeral Director	5. Social Security Number 221-10-4317 6. Sex 1 M 2X F 81	Hrs. 8. Date of Birth (Month, Dey, Year) October 11,1918	Birthplace (State or Foreign Country) Delaware								
2 8 4	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town	or Location		10d. Inside City Limits							
Man Man	Maryland Prince George's Lanha	ım		1XXYes 2□No							
0 238 C.C.	Maryland Prince George's Lanha	10l. Zip Code		n of Whet Country?							
		20706	U.S	.A.							
1	11. Maritel Stetus 12. Wes Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Merried 1 Never Married 2 Merried	13. Was Decedent of Hispanic Origin' If Yes, specify Cuban, Mexican, P	7 (Specify Yes or No- uerto Rican, etc.)	Reca - American Indian, Bleck, White, etc.							
020	3 ₺ Widowed 4 □ Divorced If Yes, Give Yeer or Detes:	1 ☐ Yes 2 ☒ No Specify:	Sp	pecify: Black							
21215-00 21215-00 di wimin 72 houn glene er than "natural" the Medical Ex	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of	adent's Usual Occupation e kind of work done during most of working DO NOT use retired)								
121 121 121 121 121	Elementery/Secondery (0-12) College (1-4or 5+)	ef of Medical Records Government									
		18. Mother's	mame)								
land lid be fi fertal H to dott fic ever	Harvey Alfred Gordon	Harriet Emma Evans									
ore, Maryland ore, Maryland set and 2 should be file of Health and Mental Hy if Heart 27 is marked other or other traumatic event		Rural Route Number, City or T									
6586		14 Tiffany Court,									
Baltimore, semit. Fages 1 a appartment of He mportant: if Nem my injury or othe mits.	20a. Method of Disposition 1 🔀 Burial 2 Cremetion 3 Removel from Stete 4 Donetion 5 Other (Specify)	02/23	wood, Maryland								
alti partin y inju	21. Signature of Funeral Service Licensee	22. Name and Address of Fecility		nood, nary rand							
00 88558	Nancus A. Percentre	J.B. JENKINS FUŃE 7474 Landover Roa		arvland 20785							
2	23a. Pert 1. Enter the disease or complications that caused the deeth. Do no shock, or heart leikers. List only one cause on each line.	ot enter the mode of dying, such es car	diac or respiretory errest,	Approximete Intervel Between							
Physician (Martins)) Or										
/Medical Examiner	disease or condition resulting in death)										
	Due to (or es a consequence of):										
oerfilicate be executed ding physician and see as the burist-trensit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.										
68760, tificate be exerging physician a as the burial-	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):										
	d.										
S, P.O. B(es that the death espect by the atterbed for the tree be detached for the tree be detached for the tree bed to the tree bed tree b	Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of										
P. C	Athenorelent fic coursio Vorsenlas 1 Yea 2 No 3 Probably Disease 24a. Was an autopsy available performed? 24b. Were autopsy available performed?										
Division of Vital Records, P.O. Bater of the death after death. Director: After this certificate has been signed by the arter by the funeral director, page 2 should be detected for the state of the s		Diseale	24a. Wes en eutopsy	24b. Were autopsy findings							
al Record The law requir cate has been s page 2 should		0.0	performed?	available prior to completion of cause of death?							
Vital Relationary The law			1 ☐ Yes 2 ☐4								
/ital	25. Wes case referred to medical	26. Place of	Deeth (Check only one)								
of Vital Richard Physician: The I	examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Out		ng Home 5 ☐ Residence 6 ☐	Other (Specify)							
Jing Pi	27. Menper of Deeth 28a. Dete of Injury 28b. Ti	jury Work?	28d. Describe how injury of	ccurred							
Attanding or death.	2 Accident Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, ten	M 1 Yes 2 No	28f. Location (Street and I	Number or Rurel Route Number,							
Div after din b	4 Homicide determined 286. Piece of injury - At nome, ten	ii, attou, today, once	City or Town, State)								
Division Control of the Hospital or Attanding P within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral directors.	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, check only one) 1 Medical Examiner: On the basis of examination and ones.	death occurred at the time, date end p for investigation, in my opinion, deeth of	lace, end due to the cause(s) an	od menner as stated. ece, and due to the cause(s)							
of the complete compl	29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
	MO 24283 2/17/2000										
(3)	30. Name and address of person was pempleted cause of death (item 33a) (item 33b) (item 33b) (item 33c) (item	ype, Print) AVE Law	rel. MO. 2	0707							
State Registra	31. Dete filed (Month, Dey, Year) FEB 2 2 2000 32 Registrar's Signature	1.									
negistrai	PED MM COOL	poorte									

DHMH 16 Rev 6/95

Sparke

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Daath 3. Time of Counth 318 PERCUARY 27, 2000 cation of Death | 4c. County of Death Gregory Conrad Hagan 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) PRINCE GEORGES HOSPITAL CHEVERLY PRINCE GEORGES CENTER If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Months XXM 2DF Yrs. 175-40-7518 46 April 7, 1953 Washington, D.C. Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City. Town or Location 10d. Insida City Limits Maryland Prince Georges Bowie 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 3936 Elan Court 20716 USA 12. Was Dacedant Ever in U.S. Armed Forcas? MXYas 2 □ No 1971 — If Yas, Giva Yaar or Dates: 75 Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status 14. Race - American Indian. Black, Whita, atc. 1 Navar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 ☐ Widowed 4 5 Divorced 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry 15. Decedant's Education (Giva kind of work dona during most of working lifa. DO NOT usa ratired) (Specify only highast grada complated) Elamantary/Secondary (0-12) Coilaga (1-4or 5+) Sheet Metal Worker Construction 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Fathar's Nama (First, Middla, Last) Nathaniel Brownfield Mary Pavalko 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Gary Wayne Hagan/Brother same as item 10 20b. Placa of Disposition (Nama of cematary, cremetory or other place) Data 20c. Location - City or Town, State 20a. Mathod of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata Metropolitan Crematory 2/29/2000 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of 22. Nama and Addrass of Facility George P. Kalas Funeral Home, P.A. 6160 Oxon Hill Rd., Oxon Hill, MD 20745 alas 23a. Part Enter the diseasa, or complications that causad the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intarval Batween Onsat and Daath Immediata Causa (Final & ARTERIOSCURIOTIC CARDIOVASCULAR DISEASE disease or condition rasulting in death) Due to (or es e consequence of): Sequentially list conditions, if any, laeding to immediata causa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3X Probably 4 ☐ Unknown CHRONIC ETHANOL ABUSE 24b. Wara autopsy findings avelleble prior to complation of cause of death? 24e. Wes an autopsy DRUG ABUSE 1 Yas 2 No 1 □ Yas 2 □ No 26. Pleca of Daath (Check only one) Other: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 1 ☐ Inpatiant 2 ■ ER/Outpatient 3 ☐ DOA 28e. Deta of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Dascribe how injury occurred 1 Naturel 5 Panding 1 ☐ Yas 2 ☐ No investigation 2 Accidant 3 ☐ Suicida

that the death certificate be executed Division of Vital Records, P.O. Box 68760, 82 esn signed by the a Hospital or Attending Physician:

Physician /Medical

Examiner

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

29a. Cartifiar

physician and the burai-transit s certificata has I director this funeral After

Physician

/Medical

Examiner

Director

Funeral

þ

Completed

Funeral

Director

the Maryland r 28a-f show

filed within 72 hours after death with Hygiene. State than "natural", or frame 23a or ent, Ita Medical Examiner must be I

Baltimore, Maryland 21215-0020 Remit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental hygiene. Important if Nem 27 is marked other than "natural", or in my injury or other traumetic event, it a Medical Exemple of the contract in the model of the contract in the model.

s after death.

25. Was case rafarred to madical axaminar? Yes 2□ No 27. Mayinar of Death

29b. Signatuse and title of certifier

6 Could not be detarmined 4 Homicide

28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. Licansa number 29d. Data signed (Month, Day, Year)

OHEVERLY

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FORRUMRY 27, 2000

cause of death (Itam 23e) (Type, Print) MARIO F. GOLLE HOSPITAL

3001 MO 31. Data filed (Month, Day, Year)

32. Ragistrar's Signatura

State Registrar

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 08733

			Cen	tificate of	Death	R	eg. No.	0 00100			
Commence of the same	1. Decedent's Neme (First, Middle, Last)		1			2. Date of Deal Month	h Day	3. Time of Death			
Physician /Medical	FRNEST	R. Hal	len,	Sr.		Februar		2000 2:00 a.m.			
Examiner	4a Facility Name (If not Institution, give :	street end number)			4b. City, Town, or	Location of Death	4c. County	of Death			
	Regency Nursing Ho			William A Was	Forestv	ille	Prince	George's			
Funeral Director	5. Social Security Number 6. Sex 578 07 2928	7. Age (In yrs. 98	last birthday) _ Yrs.	Months Days			25,1901	9. Birthplece (State or Foreign Country) WashingtonDC			
and land	10a. Slete 10b. County	10c. City	y, Town or Loc	cation				10d. Inside City Limita			
28-f ah outred	Maryland Prince Ge	orge's	Foresty	T-			0- 02	1 Yes 2 No			
of the manufacture of the manufa	10e. Street and Number 7420 Marlboro			10f. Zip Code 207			0g. Citizen of W USA				
020 urs after er, or its	11. Marital Status 1 □ Never Merried 2 □ Merried 33 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in U, Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes:		Vas Decedent of Yes, specify Cul		Specify Yes or No- rto Rican, etc.)	Bleck	- American Indian, k, White, etc. White			
nd 21215-002 se filed within 72 hours lat hygiene. softer than "naturel," over, fra Medial Ex-	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Decede	ent's Usuel Occu	upation e during most of wo ed)	orking	16b. Kind of Business/Induatry				
vithin vithin sene.	Elemantary/Secondery (0-12)	College (1-4or 5+)									
	6th 17. Father's Nema (First, Middle, Last)		Auto	Auto Mechanic Private 18. Mother's Nama (First, Middle, Maiden Sumame)							
Maryland d 2 should be file th and Mental Hy 7 is marked othe traumatic event	David E. Haller				Jennie		vialoen Somani	6)			
larylar larylar s should be and Menta s marked humetic ex	19e. Informent's Name/Reletionship (Ty)	pe. Print)	19b. Mailine	n Address (Stree		Rural Route Number	. City or Town.	Stete, Zip Code)			
CENL	Jane Wencel/daught		1.00			Temple H					
0 - 1 E S	20a. Method of Disposition		lece of Dispos	sition (Name of satory or other pla	ace)	Date	20c. Location -	City or Town, Stete			
0 0 0 0 0	1 □ Burial 2 □ Cremetion 3 □ R 4 □ Donelion 5 □ Other (Specify)	,Maryland									
Baltim cemit. Pag bepartment important: i eny injury o	21. Signeture of Funerel Service License	Priscoe Ton	uc) 22.	Name and Addr	ress of Facility MAR	SHALL'S F	UNERAL	HOME			
	23a. Part1. Enlar the disease, or complishock, or heart feilure. List only on	cetions that caused the death						Approximete			
Physician	shock, or heart tellure. List only on	e ceuse on eech lina.		$\overline{\mathbf{Q}}$				Interval Between Onset and Deeth			
/ /Medical	Immediate Causa (Final disease or condition	Asnin	dia	1/2	en-			31			
Examiner	resulting In deeth)	Due to (o	ras a consequ	uence of):	001	7 .					
od sin		Aut	M	Codil	chifa	_		16.			
68760, fleate be executed physician and is the bunat-transit edical Examiner	Sequentially list conditions, if any, leeding to immediate										
be e burie burie	cause. Enter Underlying Ceuse (Disease or Injury		305								
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death cerdent of the story of for use	d										
o deal	Pert II. Other aignificant conditions con	Inbuling to death but not resu	23b. Did to	obacco use cor	tribute to the cause of death?						
Is, P.O. BOX es that the death ce igned by the attendic be detached for use by Physician/			1 Yea 2 No 3 Probably 4								
ecord aw requir ts been s 2 should pleted						24a. Wes a perform	n autopsy med?	24b. Were autopsy findings evallable prior to completion of cause of deeth?			
The page						1 U Y	as 2½ No	1 Yas 2 No			
Of VIta Physician: this certific ral director,	25. Wes case ratarred to medical axaminer?	a an itali		1-		eath (Check only or	16)				
To To	1 1 105 2 LA 140		ER/Outpatient	JU DON		Home 5 ☐ Reside					
Ing P	27. Manner of Deeth 1 ☑Naturel 5 ☐ Pending	28a. Data of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inje	ury et ork? ⊒ Yes 2 ⊒ No	28d. Describe h	ow injury occurr	ed			
Division of Vital Riving the Hospital or Attending Physician: The lighth 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page. Medical Certification: To Be Com	2 Accident investigetion 3 Suicide 6 Could not be 4 Homicida determined	28a. Place of Injury - At he building, etc. (Specify	ome, ferm, stre			281. Location (S City or Town		er or Rural Route Number,			
To the Hospital of within 24 hours a No the Funeral D completely filled i	29a. Cartifiar (Check only one) 1 Certifying Phya	Iclan: To the best of my knower: On the basis of axaminet and manner steted.	wledge, death tion end/or invi	occurred at the tastigation, in my	tima, data and plac opinion, death occ	ce, and due to the courred at the time, d	ause(s) and ma ata and place, a	nnar as stated. and dua to tha cause(s)			
ithin omp	29b. Signature and title of certifier			29c. Licer	nse number	2	9d. Date signed	(Month, Dey, Year)			
	1/118			DV	626	(2-27	2-7000			
(6)	30. Neme and addrass of person who con	mpleted causa of daath (Item	23a) (Type, P	Print)	- 3 - 50 -		01 01	Allinber			
9	Michael (in)	7 Rous 1170	ol lin	riassto	· NJ	A(1)	77 ~				
State	31. Dete filed (Month, Dey, Year)	32. Registrer's Signe	ture /	1			97	0196			

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene 08734 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death M. HICKMANY **Physician** JAMES 0153 23 2 3 /2000 4c. County of Death /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death **Examiner** Prince George's Hospital Prince George's Cheverly 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 43 Yrs. | Months | Days | Hours | Min. | Sept. 14, 1956 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F 579-76-1946 Maryland Director Usuel Residence of Decedent the Maryland 10b. County 10a. Stete 10c. City, Town or Location 10d. Inside City Limits rms 23a or 28a-f show 1√2 Yes 2□ No Director Maryland Prince George's Seat Pleasant 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 710 - 66th Avenue 20743 United States Funeral death Nems 2 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Stetus Hygiene. ther than "netural", or item mt, the Mades Example. Bleck, White, etc. filed within 72 hours after 1 Never Merried 2 ☐ Merried 21215-0020 1 Yes 2√ No Specify: Specify: Black by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electronic Technician Government permit. Pages 1 and 2 should be filed Oppertment of Health and Mental Hygi Important: if Item 27 Ia marked other any Injury or other traumatic event. Baltimore, Maryland 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Clarence Jerome Hickman Lillian W. Brown 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirlene Beard - Sister 710 - 66th Ave., Seat Pleasant, MD 20743 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 Buriel 2 Cremetion 3 Removal from State Harmony Memorial Park 2/29/2000 Landover, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licenses 4001 Benning Rd., N.E. Wash., D.C. 20019 work 23a. Part1 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset and Deeth **Physician** Due to (or as a consequence of):

tastatic Malignant Melanoma

Due to (or es a consequence of): /Medical Immediete Cause (Final diseese or condition resulting in death) Examiner Box 68760 Physician/Medical Pert It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably Wunknown þ 24b. Were autopsy findings evailable prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes ZX No 4 27. Manger of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Affiar Natural 2 Accident or Attending 5 Pending w Hospital or Attendin n 24 hours after death. w Funeral Director: Att 1 | Yes 2 | No investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of tnjury - At home, farm, street, fectory, office building, etc. (Specify) Continuing Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and menner as stated.

Continuing Physician: To the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. Medical To the T Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 29205 16 00 eme and adduss of person who completed cause of death (Item 23a) (Type, Print) Felipe Robinson 4987 Battery Lane, Bethesda, MD 20814

DHMH 16 Rev 6/95

State Registrar

31. Date filed (Month, Dey, Year)

32. Registrar's Signeture

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State	of Maryland	Denartment	of Health	and	Montal	Hygien
State	or waryland /	Department	OI I I Calti	and	IAICIIIGI	riygich
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# www.compression.	1. Decedent's Neme (Firs	t, Middle, Last)						2. Date of Deat	h	**	Time of Death
Physician /Medical	CHARLES	KENNETH HAR	VEY					Month Februar	y 14	2000 08	8:05 A.M
Examiner	4a Facility Name (If not in	nstitution, give street and 2608 Fairla					wn, or Loc le Hi	ation of Death	4c. County	of Death e George	216
	5. Social Security Number		7. Age (In yrs.		If Under 1 Ye	_		R Date of Birth			
Funeral Director	578-44-2709	1 M M 2□	F 64	Yrs.	Months Da		Min.	(Month, Day, IUNE 25	Year)		(State or Foreign GTON DC
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with the Ma or 2844 a be notified		INCE GEORGE	S	EMPLE	HILLS						Yes 2□No
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r Items 23 diper must Funeral	11. Merital Stetus 1 Never Married 2	Armed 1 □ Y	Decedent Ever in U, d Forces? 'es 2 🛛 No		Wes Decedent of Yes, specify C			city Yes or No- lican, etc.)	Bla	ck, White, etc.	dian,
Example 1	3 ☐ Widowed 4 ☐ D	If Yes	or Detes:		1□ Yes 2⊠i	No Specify:		6174	Specif	r: BLACK	
or the Medical.	15. D (Specify onl)	ecedent's Education y highest grade complet	red)	(Give	dent's Usuat Oc kind of work do	ne during mos	at of working	9	16b. Kind of B	usiness/Industry	
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	19e. Informent's Name/R									, State, Zip Code	9)
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	20a. Method of Disposition	n metion 3 □Removal fr		race of Dispo emetery, cre	netory or other	place)		Date	20c. Location	- City or Town, S	itate
	4 □ Donation 5 □ C			. OLIV	VET CEME	ETERY	į 2	-28-00	WASHI	NGTON D	C
T S	21. Signature of Funerel S	Service Licensee	0	22	2. Neme and AC	dress of Facili	S. PO	PE FUNE	RAL HO	ME	
# St	1 West	Atoni	A							MD 2074	7
	23a. Part1. Enter the dise shock, or heart feilu	ese, or complications the	at caused the deet							Appr	roximete val Between
the hes been signed by the ettending physician and page 2 should be detached for use as the burial-transit.	disease or condition resulting in death) Sequentially list condition if any, leeding to immedia cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b	Due to (o	r as a consec r as a consec r as a consec	quence of):	D And C	1621				
igned by the etten be detached for u by Physician	Part II Other steniffsent	anditions and that is a	to death but not son	obine in the s		share in Dark		92h Did to	hanna 1100 on	market and a thin .	cause of death?
y Phys	Part II. Other algnificant of	conditions contributing t	to death but not rest	uiting in the u	noenying cause	neч in nevigi		1 \(\text{Y} \)	. /	THE PARTY OF THE P	4 Unknown
Completed by Physician/Me		100			6.0			24a. Wes as perform		available	utopsy findings e prior to tion of cause 1?
rector, page 2								1 X Ye	s 2 No	1 Yes	2 □ No
Be C	25. Was case referred to	medical				26. Plan	e of Death	(Check only on		1	
To B	axaminer? 1∑ Yes 2 No	Hospital:	I npatient 2	ER/Outnaties	nt 3 DOA	Other		e 5 X Reside		her (Specify)	
	27. Manner of Death	28a. D	ete of Injury	28b. Time o	-	njury at Work?	-	8d. Describe ho			
Certification:	1 □Netural 5 □ 2 □ Accident	Pending (/ investigation 2	Month, Day Year)	17:59		Work? 1 ☐ Yes 2	No	512-	ACT ACT	HULTED	
Hick	3☐ Suicide 6☐	Could not be 28e. P	lece of Injury - At ho	me, ferm, st	reet, lectory, off	ice	2	81. Location (St	reet and Num	ber or Rural Rou	rte Number,
ert	4)K Homicide	b	uilding, etc. (Specif)	" Home				City or Town	i, state) ZU	08 FAIRLAU	ih streat
edicai C		Certifying Physician: To ledical Examiner: On the and r		wledge, deat	h occurred at th						
completely filled in by the Medical Certifical	29b. Signeture and title of				29c. Lic	ense number		2	9d. Date signe	ed (Month, Day,	Year)
	•	VM. 7	4		C	.C.M.E	•		Febr	uary 15,	2000
	30. Name and address of	person who completed o	cause of death (Item	23a) (Type,		- 61				1 7 6	1203
	JHCK MI	71745, M.D.			III Pen	in Stree	et, B	altimor	e, Mar	yland 21	1201
State	31. Date filed (Month, Day	, Year) 3	2. Registrar's Signa	ture							

DHMH 16 Rev 6/95

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 7:15 a.m Month HOUSTON REBECCO FEBRUARY 20 2000 4a Facility Name (If not Institution, give streat end number) 4b. City, Town, or Location of Deeth 4c. County of Death PRINCE Caks NSG. 4 REHAB. CENTER CLINTON GEORGE'S If Under 1 Year | If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number Birthplaca (Stete or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 80 578-36-9643 July 26, Florida Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Oxon Hill 1K Yes 2 No 10e. Street and Number 10f Zio Code 10g. Citizen of What Country? U.S.A. 20705 1100 Owens Road, Apt. #511 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☒ No 1 Yes 2 No Specify: Black Specify: 3♥Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Domestic Worker Private 10th 17. Fether's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Goldyere Rufus Alexander Rebecca 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Geraldine Ferguson/Daughter 1100 Owens Road, #511, Oxon Hill, Maryland 20705 20b. Place of Disposition (Nema of cemetery, cremetory or other plecs) 20e. Method of Disposition 03704 20c. Location - City or Town, Stete 1 X Burial 2 Cremation 3 Removal from State Forest Hills Mem. Gardens 2000 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 21. Signature of Furieral Service Licenses J. B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or haar failure. List only one cause on each line. Approximate Interval Between Onset end Death asclenotic Comprovagana Dilass Immediata Cause (Final disease or condition resulting in death) Sequantially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was en autopsy performed? completion of cause of death? 20 No 1 ☐ Yes 2 ☐ No 25. Was casa raferred to medical axaminer? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 540 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

28d. Describe how injury occurred

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

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1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Physician

/Medical

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Funeral

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Funeral

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'natural', or lisens 23s or

Hygiene.

permit. Pages 1 and 2 should be file Depurtment of Health and Mental Hy Important: If Nem 27 is married other any injury or other traumatic event

hours after

Baltimore, Maryland 21215-0020

The law requires that the death certificate be executed physician s the burial Box 68760. P.O. I signed by Records. page 2 Division of Vital

or Attending Physician: After this funeral efter death. filled in within 24 hours of To the Funeral D completely filled i Hospital å

5

State Registrar

20b. Signature and title of certifier

5 Pending investigation

6 Could not be datarmined

28a. Data of Injury (Month, Dev Year)

who complated cause of death (tem 23a) (Type, Print)

Dete filed (Month, Dey, Year) MAR 8 1 2000

32. Registrar's Signature

28b. Time of Injury

28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28c. Injury at Work?

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated.

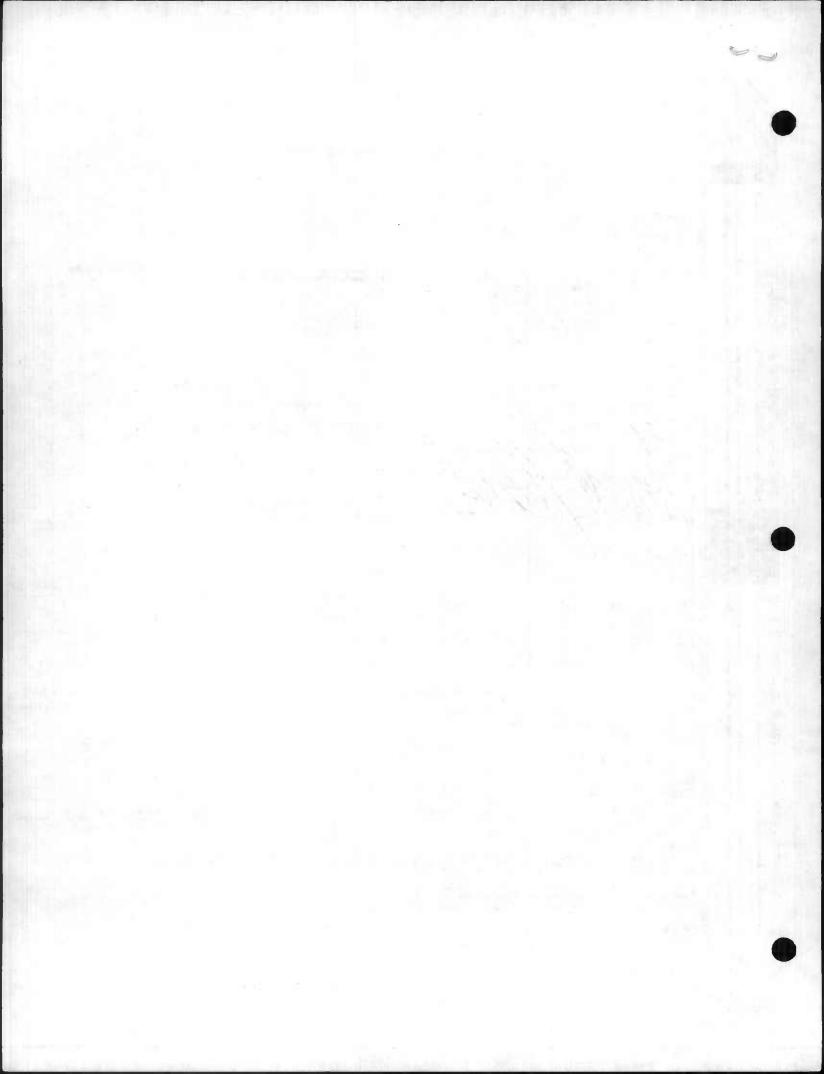
29c. License number

1 Tas 2 No

DHMH 16 Rev 6/95

MAR 9 5 2000 Second & Special

vw.	Amend #19a HCH			Certificate of			Reg. No.	08737	
Physicia	1. Decedent's Name (First, Middle, I			gradent.		2. Date of De Month	ath Day Ye	3. Time of Death	
/Medica	John Earle H	arris, Jr.			th Ch. Town and	Februa	ry 28,200		
Examine	2005 Cherry Roa				4b. City, Town, or L Edgewood		4c. County of E		
Funeral			In yrs. last birtl	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.			Birthplace (State or Foreign	
Director	186-24-1154	163 M 2 L F	68 Y	rs. Months Days	TIOUIS WINT.	8. Dete of Bir (Month, Da Apr. 23	, 1931 Pe	ennsylvania	
dand dand	Usual Residence of Decedent 10a. State 10b. County	1	Oc. City, Town	or Location				10d. Inside City Limits	
Mary offed	Maryland Harf	ord	Edge	wood				1 ☐ Yas 2 ☐ No	
vith the Ma or 28a-f a	10e. Street and Number	-7		10f. Zip Code	• • •		10g. Citizen of Wha		
fier death v	2005 Cherry	RCL . 12. Was Decedent Ev	er in IIS	210		ecity Ves or No	USA 14 Bace -	American Indian,	
d 21215-0020 G 21215-0020 Illed within 72 hours after death with the Maryland Hygiene. Hygiene. Ther then "natural", or items 23e or 28e-1 show ent, tre Medical Exercise invest to indifical.	1 Never Married 2 Merried 3 Widowed 4 Divorced	Armed Forces? 1 Types 2 No If Yes, Give		If Yes, specify Cube				White	
15-0020 72 hours aff		Education	16a	Decedent's Usual Occup	ation	ina	16b. Kind of Busin		
Maryland 21215-0020 If a should be filed within 72 hours at the and Mental Hygiene. The merked other than "natural, or trainment avent, tre Medical Enter	Elementary/Secondary (0-12)	College (1-4or 5+)		(Give kind of work done life. DO NOT use retired					
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ylanc wid be fil Mental H rked off				Trainer					
ary market	19a. Informant's Name/Relationship		19b.	Mailing Address (Street	and Number or Rui	al Route Numbe	er, City or Town, Sta	te, Zip Code)	
C = 20 F		III , Son		005 Cherry Disposition (Name of	Rd., Edge	-		7	
Pages 1 a next of Hea ant: if Hean arry or othe	20a. Method & Disposition 1 Physic 2 Cremation 6 4 Disposition 5 Other Care	Regional jobs State	cemetery	crematory or other place		Dete	20c. Location - City		
artime Portant	Systemation 5 Light Spece Lio	1 600	Hillto	Service C	ss of Facility		Towson, M	aryland	
m age ag	XXX NOWN 7	1 AM/14	4	McComas I	Funeral H			21000	
	3a Part Enter the dispass of co- shock, or hear vallure. Unit on	mp alions that caused the	e death. Do no	ot enter the mode of dyir	ng, such as cardiac	or respiratory a	ngdon, MD	Approximate Interval Between	
Physician / /Medical	1 //		27	14				Onset end Death	
Examiner	Immediate Cause (Final disease or condition resulting in death)	Chronic						1	
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oxecuted in and riel-transit	Sequentially list conditions,	b	e to (or es a co	onsequence of):					
58760, icate be secuted icate be secuted physician and is the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	C							
	resulting in death) Last	Du	e to (or as a co	onsequence of):					
death certification of for use as		d							
P.O. BOX at the death certi dby the attending etached for use	Part II. Other significant conditions	contributing to death but i	not resulting in	the underlying cause giv	ren in Part I.	23b. Did	tobacco use contril	bute to the cause of death?	
		on				10	Yes 2/2/No 3	Probably 4 Unknown	
HECOTGS, P te lew requires that that bear signed b tge 2 should be dete								4b. Were autopsy findings	
law recent as bee							nited	available prior to completion of cause of death?	
- F = 2						183	Nes 2□No	1 🗗 ¥es 2 🗆 No	
ysician: The ysician director, pag	25. Was case referred to medical examiner?	U		Lou	26. Place of Deel	th (Check only o	one)		
To the sign of the			2 ER/Out		4 □ Nursing Ho		dence 6 Other (Specify)	
ding th.: After tune	12 Natural 5 Panding 2 Accident investigati	28a. Date of Injury (Month, Day Y	k? Yes 2 □ No	200. 00001001	now injury occorred				
DIVISION OF tal or Attanding Phys is after death. al Director: After this ied in by the funeral di	3 Suicide 6 Could not 4 Homicide determine			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	29a. Cartifier (Check only (Ch								
the F	29a. Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mc								
5 × 5 8	1 / L	1/ 11/	T 11		C.M.E.		February		
15	30. Name and address of person who	o completed cause of dear	th (Item 23a) [7	Type, Print)					
1	Stephen Rad			Penn Street	t, Baltim	ore, Ma	ryland 21	201	
State Registrar	31. Date filed (Month, Day, Year) MAR 1 -	2000 32. Registrar's		b. Spar	h			746	



State of Maryland / Department of Health and Mental Hygiene 10 08738

										Death			leg. No.		
E000000	1000	1. Decedent's Nam	ne (First, Mid	idle, Last)								2. Date of Deat Month	th Day	Year	3. Time of Death
Physic /Med		MARY FRA	ANCES I	HOLM	ES							MARCH		2000	2:35 PM
Exami		4a Facility Name ((If not instituti	ion, give :	street and nu	m <i>ber)</i>				4b. City, To	wn, or Lo	cation of Death	4c. County	of Death	
		MERRIDIA	AN NUR	SING	HOME					LA I	PLATA	1	CHAI	RLES	
Funeral		5. Social Security N	Number	6. Sex		7. Age (in yn	s. last birthdey)	If Under 1	Year	If Under Hours	24 Hrs.	8. Date of Birth (Month, Day,	Year)	9. Birthpla	ce (Steta or Foreig
Director		217-36-8	3770	1]M 2020 F	8	9 Yrs.	Months	Days	Hours		SEPT. 1		MARY	
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or 28	Director	10e. Street and Nu	mber					10f. Zip (Code			-1	l0g. Citizen of V	What Country	y?
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72 hours after death with the Maryland naturel; or items 23a or 28a-f show after Examiner must be recitied at	Funeral	11. Meritei Stefus				edent Ever in	U,S. 13.		20675 Decedent of Hispanic Origin? (Spec s, specify Cuban, Mexican, Puerto R					e - American	n Indien,
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urs a	by	3 ⊠ Widowed	4 Divorce	ed	If Yes, G	ive Dates:		1□ Yes 2	E-No	Specify:			Specify	BLAC	K
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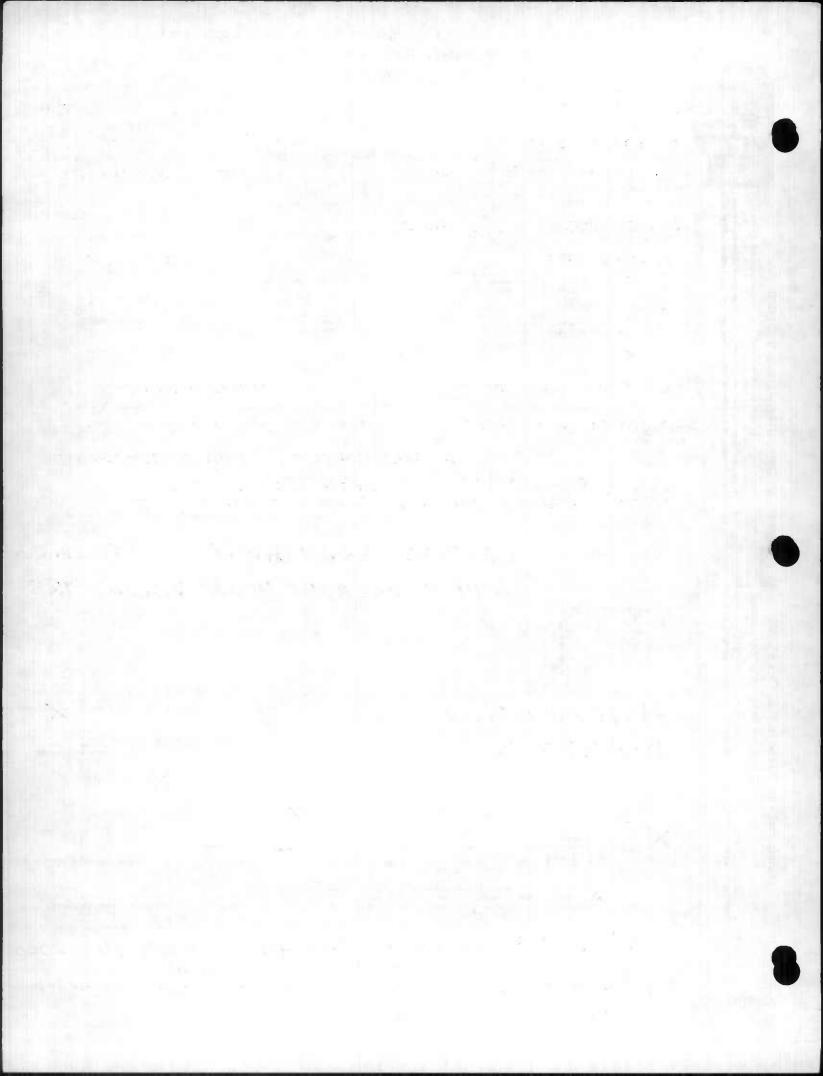
6 INDUSTRIAL PARKOR WOLDORF MD 20601

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHVINKYMAR

MAR 07 2000

31. Date filed (Month, Dey, Yeer)



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** Dorothy May Hooper March 1, 2000 2:05 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick H Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months Days 1 M 2 X F Hours 220-28-7848 Director 5, 1932 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Yes 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 10404 Old Annapolis Rd. 21701 U.S.A. flarms 23a Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

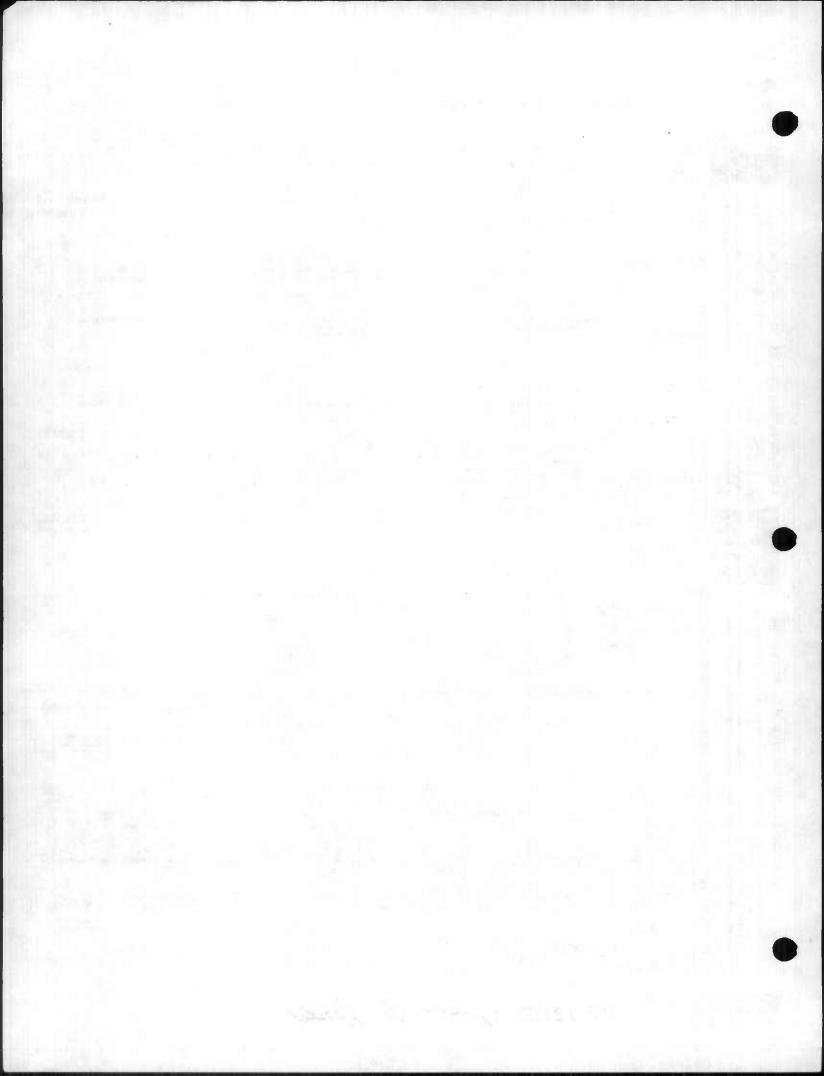
1 Yas 2 No If Yes, Give Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 ☑ No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene."n soda fountain/ Elementery/Secondary (0-12) College (1-4or 5+) 10 waitress/ wear tester rubber co. permit. Pages 1 and 2 should be filed.
Department of Health and Mentai Hyg.
Important: If Nem 27 is marked other any injury or other traumented other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Riley Ellsworth Hooper, Sr. Mary Lucinda Lettire 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) 10404 Old Annapolis Rd. Frederick, MD 21701 Christine Brandenburg/ sister 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stete Bethany Cemetery 3/4/00 nr. Taylorsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licensee 11802 Liberty Rd. Libertytown, MD 21762 23a. Part1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each time. Approximete Intervel Between Onset and Death **Physician** /Medical immediate Cause (Final Invercey diseese or condition rasulting in death) Examiner Examine Commun physician and the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or as a consequence of) 950 signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Chrune Records, þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No Wille 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 20 No 1 Unpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 28c. Injury at Work? Affer or Attending 1-Netural 5 Pending investigation n 24 hours after death.
The Funeral Director: After the funeral of 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the Hosp within 24 hou To the Fune completely fi (Check only one) 29b. Signature and little of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fraery Int 21702 HALLUSIN m Tany 31. Data filed (Mooth, Day, Year) 32. Registrat's Signature

DHMH 16 Rev 6/95

State

Registrar

MAR 0 2 2000

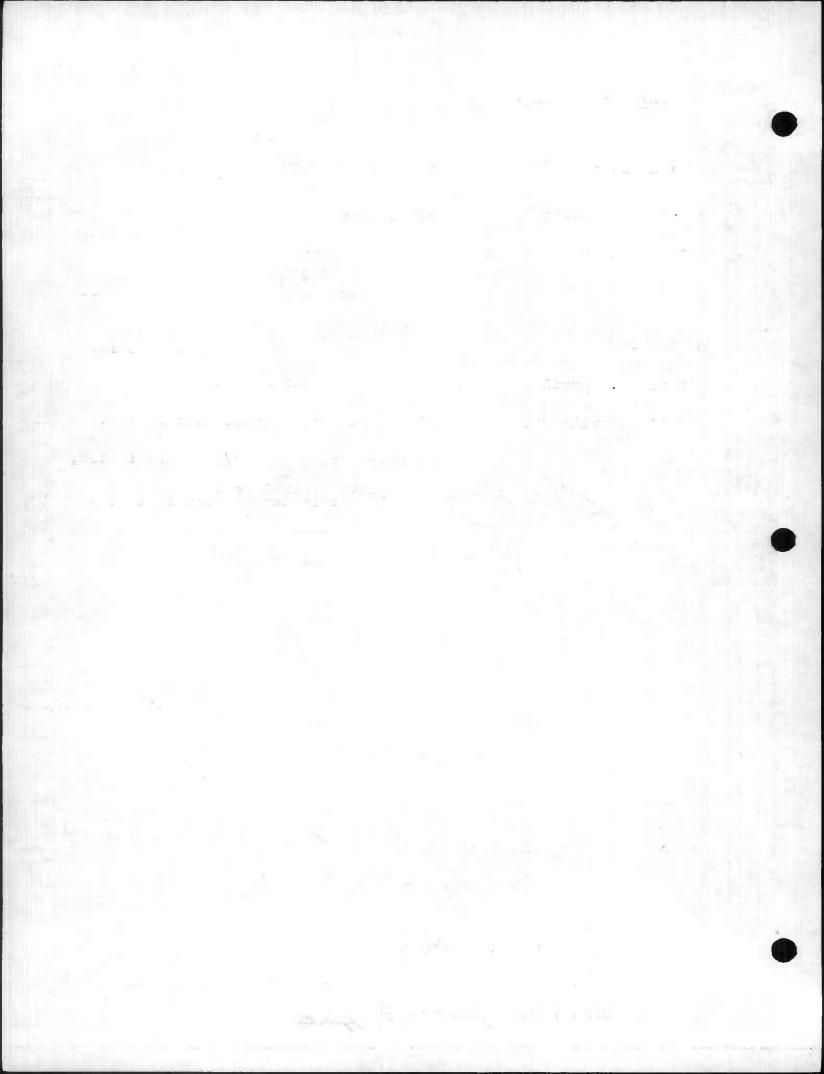


State of Maryland / Department of Health and Mental Hygiene

Cortificate of Death

00 08740

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Physician /Medical	1. Decedant's Nama (F David Al	lan Ha	rvilak						2. Date of De Month FEBRUA	Day	3. Time of Death 2000 16:45
Examiner	4a Facility Nama (If no 2700 EMOR)		ve street and no	umber)			4b. City, To		cation of Death ER	4c. County CARRO	
Funeral Director	5. Social Security Number 218-08-42	216	Sex ¥⊡M 2□F	7. Aga (In yrs. las	t birthday) Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Data of Bir (Month, Da Dec 2	y, Year)	Birthplace (State or Fore Country) VA
1	Usual Rasidance of Da 10a. Stete 10	b. County		10c. City.	Town or Lo	cation					10d. Inside City Lim
one		Carrol	1			nster					1 (X) Yes 2 1
or 28	10a. Street and Numbe				MA	10f. Zip Code				10g. Citizen of 1	What Country?
23a	154 East	Green	Stree	t		2	21157			U	SA
al, or flore 23a or 28a-f show Examiner must be notified at by Funeral Director	11. Marital Status 1 Nevar Married 3 Widowed 4		Armed F	2₫No iva	100	Was Decedent of it Yes, specify Cut ☐ Yes 2 No		gin? (Spe , Puerto	cify Yas or No Rican, atc.)	14. Rac Bta	e-American Indian, ck, White, atc. White
and Mental Hygiena. Is marked other than "natural", or sumatic avent, the Medical Earn To Be Completed by F	(Specify of Elementary/Seconda 1.2		ade completed,) (1-4or 5+)	(Give life. L	lent's Usual Occu kind of work done DO NOT use retire	during most	t of worki	ng	16b. Kind of B Congo Indus	
7 is marked other traumatic avent, To Be Co	17. Father's Nama (First David A.		,						(First, Middle, Efaw	Maiden Suman	ne)
auma auma	19a. Informant's Name	/Relationship (Type, Print)		19b. Mailin	g Address (Stree	t and Numbe	er or Rura	I Route Numb	er, City or Town,	State, Zip Code)
The state of the s	Kelly Har	rvilak	/wife		154	East G	reen	Str	eet We	stmins	ter, MD 211
or other t	20a. Mathod of Disposit		Removal-from	Stete	etery, cren	sition (Name of natory or other pla			Data		City or Town, State
ortant: Injury	4 □ Donation 5 □	Other (Special	M) /	Me	adow	Brancl	1	1	3/3	Westm	inster, MD
Department of the Important: If its any injury or of page.	21. Signature of Funera	at Sarvice Lice	7600		P	Name and Addr ritts 1 12 Was1	Funer	al I	Home a	nd Cha	pel er, MD 2115
ding physician and sa as the burial-transit a	Immediate Causa (Fina diseasa or condition resulting in death) Sequentially list condition and the causa. Enter Underlyin Cause (Disease or Injuthat initiated evants resulting in death) Last	lons, diata ng	b	Due to (or a	s a conseq	uence of):		ry		18	
d by the atterdateched for u	Pert II. Other significan	nt conditions o	d	leath but not resultin	ng in the ur	nderlying cause gi	iven in Part I.			tobacco use co Yes 2 No	ntribute to the cause of dea
2 should									24a. Was	an autopsy armed?	24b. Were autopsy finding available prior to completion of cause of death?
Corr									10	Yas 2□No	1 🗗 Yas 2 🗆 No
director, pag	25. Was case referred taxaminar?	to medicat	Hospital:		-	0:	hor		(Check only o		
within 24 hours after death. To the Funeral Director: After this complately filled in by the funeral director. Medical Certification: To	2 Accident 3 Suicide 6 4 Homicide	Medical Exam	28a / Place build pysician: To the niner: On the b	e of Injury - At home ling, atc. (Specify)	3b. Tima of Injury 531 a, farm, stra 23 dge, death	28c. Inju Wc 12 eet, factory, office Cocurred at the ti	iny at investment of the control of	No Place,	Subjection (City or Ton	Street and Numi	trid Equipoper or Aural Route Numbers Lung, Ma
To oc	•	Pis	tan	er, M	(-D	O.C.N					Y 29, 2000
	30. Nama and diddless	JOS9P	oh Pe	S Town & Registrar's Signature	(111		reet,	Bal	timore,	Maryla	nd 21201



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3 Time of Death JOHNSON II HNOY 3:40 pm 29 2000 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth MOUNT WASHINGTON PEDIATRIC HOSPITAL BALTIMORE 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 6. Sex 1 ☑ M 2 ☐ F 5. Social Security Number Birthplece (State or Foreign Country) Months Days 219-55-9811 Sept. 30, 1999 4 Maryland Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. inside City Limits 1 Yes 2 No Maryland Cecil Colora 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 129 Macintosh Drive 21917 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 0 N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Andy Ray Johnson, Sr. Angela Masker 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andy Ray Johnson, Sr. 129 Macintosh Dr., Colora, MD 21917 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 1X Burial 2 Cremetion 3 Removei from State 4 ☐ Donetion 5 ☐ Other (Specify) West Nottingham Cemetery 3-4-00 Colora, Maryland 22. Nome and Address of Facility
R. T. Foard Funeral Home, P. A.
111 S. Queen St., Rising Sun, MD 21911 21. Signeture of Funeral Service Ligar use, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the of shock, or heart Approximate Intervel Betw Onset and Death Immediate Cause (Final RESPIRATORY FAILURE diseese or condition resulting in death) Due to (or es a consequence of): EPILEPTIC ENCEPHALOPATHY Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Diseese or trijury that Initiated events resulting in deeth) Lest Due to (or es e consequence of): INTRACTABLE SEIZURES Due to (or es e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown PAPILLO RENAL SYNDROME 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

physician and s the burial-transit

signed I

Box 68760

P.O.

Division of Vital Records.

Physician

/Medical

Examiner

Directo

Funeral

þ

Completed

Funeral

Director

7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be nothed at

permit. Pages 1 and 2 should be filed within: Department of Health and Mertel Hygiene. Important: If item 27 is marked other than "r any lighty or other traumatic event, if a Heal office."

the Marylend

72 hours efter

Baltimore, Maryland 21215-0020

Examiner Physician/Medical A Q Completed Be 2

25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospital: 1 patient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 27. Manner of Deeth

28e. Date of tnjury (Month, Day Year) 5 Pending investigation N/A 6 Could not be determined

28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street end Number or Rural Route Number, City or Town, Stete)

(Check only one) 29h Signature and title of certifier

1 Netural 2 Accident

3 Suicide

29a. Certifier

4 Homicide

1 Certifying Phyalclan: To the best of my knowledge, deeth occurred et the time, dete and pleca, and due to the ceuse(s) end menner as steted.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the ceuse(s) end menner stated. 29d. Date signed (Month, Dey, Year)

29c. License number ATTENDING D 0054714 agentul M.D. PHYSICIAN

30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) TREVOR VALENTINE H.D. MOUNT WASHINGTON PEDIATRIC HOSPITAL, 1708 W. ROGERS AVE, BALT. MD 21209

State Registrar

31. Date filed (Month, Day, Year) MAR 0 3 2000

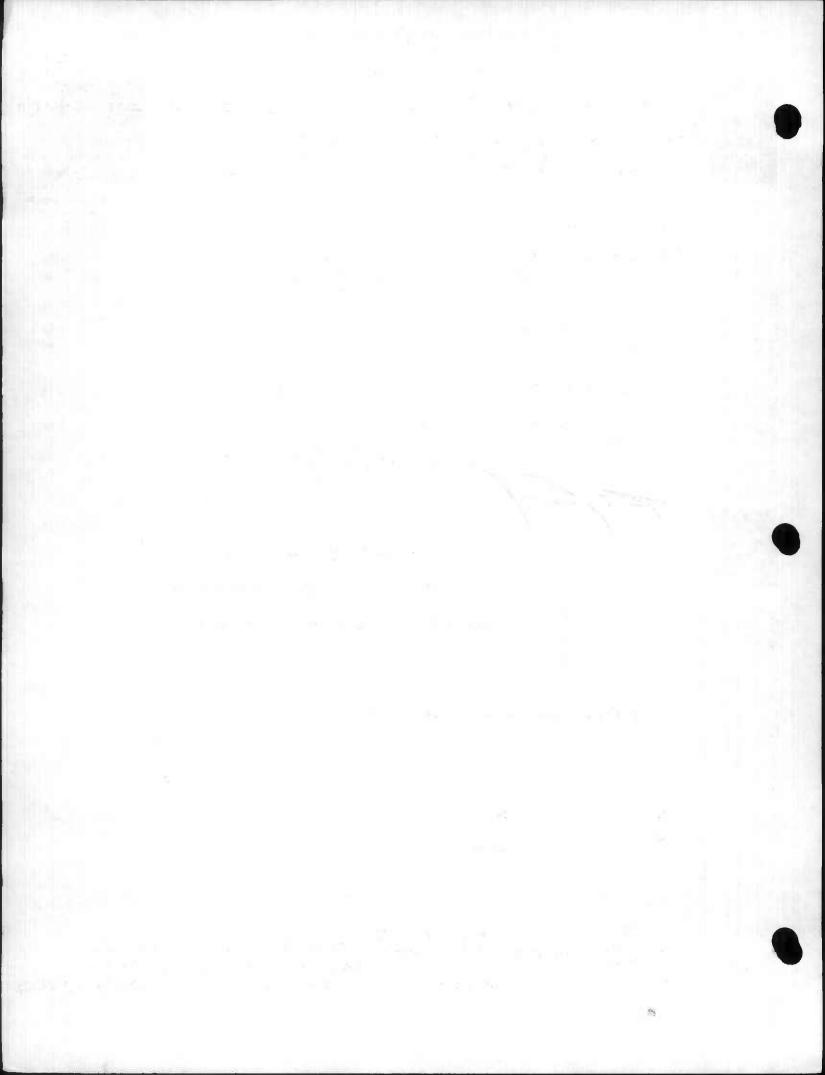


DHMH 16 Rev 6/95

To the Hospital or Attending Privithin 24 hours after deeth.

To the Funeral Director: After the completely filled in by the funera

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an al	Allan Hind	ls Johr	nson							EBRUA	RY 26,2	000	6:45P.	М.
er	4a Facility Name (If not in:	stitution, give	street and numbe	or)				4b. City, Town	n, or Loca	tion of Deat	h 4c. Count	ty of Death		
	6207 60th P 5. Sociel Security Number 039-22-0350	6. Se	x 7. / ZM 2□ F	Age (In yrs.	last birthday Yrs.	y) If Under	er 1 Year s Days	RIVERI If Under 24 Hours	Hrs. 8 Min.	Date of Bir (Month, Da .ug. 2	rth .	9. Birthp Coun Rhod	ORGES lace (State or I try) e Islan	oreign
	Usuel Residence of Deced	dent County		10c, Ci	ity, Town or I	ocation						1	Od. Inside City	Limits
tor			eorge's		verda]							T	1 Ves 2	
Directo	10a. Street and Number			1			ip Code				10g. Citizen of	What Coun	try?	
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by runeral	11. Marital Status 1 Never Married 22 3 Widowed 4 Dir		12. Wes Deceder Armed Force: 1 ☑ Yes 2 ☐ If Yes, Give Year or Date:	s?]No 195	57-	Was Dec		fispanic Originan, Mexican, I Specify:	n? (Specif Puerto Ric	y Yes or No an, etc.)	14. Ra Bla Speci	ice - Americ ack, White, ify: Wh		
0316	15. De	ecedent's Edu	ucation le completed)		16a. Dec	edent's Us		nation during most o	f warding		16b. Kind of E	Business/Inc	lustry	
Completed	Elementery/Secondary (1	College (1-4o	r 5+)	life.	DO NOT	use retire	d)						
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0 20	Ernest Walte		nson								ine Hin			
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	Kylle Johnso	on - W	ife		6207	60th	h Pla	ce, Ri	verd	ale, N	Maryland	d 2073	37	
	20a. Method of Disposition 1 ☐ Burial 2 ☒ Crem		Removel from Stat		Place of Disponentery, on	position (Na ematory or	ame of other plac	ce)		Date	20c. Location	- City or To	wn, State	
	4 Donetion 5 Of	ther (Specify))	Me	tropol				2/:	28/00	Alexar	ndria,	Virgi	nia
	21. Signeture of Funeral S	Service Licens	t 1 2	100	./	Gasch	's F	ss of Facility uneral	Home					
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State of Maryland / Department of Health and Mental Hygiene

December Name (First Addes, Lary Joseph A. Jenkins, Sr. 2. Does of Dearm Courty of Large Courty of Jenkins (Private Courty of Jenkins) (Privat				(Certifica	ate of	Death		Reg. No.	0 08	143
Southern Maryland Hospital Center Co. Chy. Ten. or Location Chy. Ten	4.4	1. Decedent's Nema (First, Middle, Las	(t)								ime of Death
Southern Mary And Hospital Center Contractor Contract Contr			Joseph	A. Jenki	ins, S	r.					2:50AM
Southern Maryland Hospital Center Third Control Third Con		4a Facility Nama (If not institution, give			,		4b. City, Town	, or Location of Dec	oth 4c. County		2.00.111
Under Residence of December 1, 18.5 steps 1 (10.5 Color), Town or Location		Southern Marylan	d Hospital	Center		-	Clinto	on	Princ	e George	e's
Under Residence of December 1, 18.5 steps 1 (10.5 Color), Town or Location	Funeral			(In yrs. last birth			If Under 24				
Under Residence of December 1, 18.5 steps 1 (10.5 Color), Town or Location	Director	578-03-3016	MM 2LF 83	Yı	3.	15 0093	Tiours	Sept.	27,1916	Washingt	ton, D.
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23a Pertl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest. Physician / Micdical Examiner Immediate Cause (Final Sease) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest. Physician / Micdical Examiner Immediate Cause (Final Sease) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest. Part II. Other eligible cause (Final Sease) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest. Part III. Sequentially list conditions, a consequence of): Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Due to (or as a consequence of): ISCHEMIC ENCEPHALOPATHY Due to (or as a consequence of): ISCHEMIC ENCEPHALOPATHY Due to (or as a consequence of): Years Part III. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. History of right hemiparesis and expressive aphasia With G. TUBE feeding, aspiration bronchitis. Renal Insufficiency with nephrosclerosis. Renal Insufficiency with nephrosclerosis. 25. Wes case referred to medical sample of the complete of the cause of death of death. 10 Yes 2 No. 10 Yes 2 No. 10 Yes 2 No. 11 Yes 2 No. 11 Yes 2 No. 11 Yes 2 No. 12 No. 11 Yes 2 No. 12 No. 12 No. 12 No. 13 No. 13 No. 13 No. 13 No. 13 No. 13 No. 14	nd 2 sho aith and N 27 is me	1	*					or Rural Route Num	ber, City or Town	, State, Zip Code)
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29a. Certifier (Check only one) 29a. Certifier (Check only one) 29b. Signatura and title of certifier 29b. Signatura and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year)	th. After the funeral	1 Neturel 5 Pending	(Month, Dey		ury				e how injury occur	rred	
29a. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 29a. Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated. 29b. Signatura and title of certifier 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and didress of parson who completed cause of death (Item 23a) (Typa, Print) PETER W. YIM M. D. 7900 OLD BRANCH AVE. SUITE 101, CLINTON, MARYLAND 20735	sa after des at Director ed in by th	3 ☐ Suicide 6 ☐ Could not be	286. Piece of injur	y - At home, term (Specify)	n, street, fac	tory, office		28t. Location City or 7	(Street and Numi own, Steta)	ber or Rurel Rou	te Number,
30. Nema and address of parson who completed cause death (Item 23a) (Typa, Print) PETER W. YIM M.D. 7900 OLD BRANCH AVE. SUITE 101, CLINTON, MARYLAND 20735	n 24 hours Funer Metely fill Adicai									cause(s)	
30. Nema and address of parson who completed cause death (Item 23a) (Typa, Print) PETER W. YIM M.D. 7900 OLD BRANCH AVE. SUITE 101, CLINTON, MARYLAND 20735	To the To the Somp	29b. Signatura and title of certifier				29c. Lican	sa number	THE RESERVE	29d. Data signe	ed (Month, Day,	Year)
PETER W.YIM M.D. 7900 OLD BRANCH AVE. SUITE 101, CLINTON, MARYLAND 20735	(A)	Poter	W PO	3 m	2	D00	12884		Feb.	24'00	
24 Data filed (Month Day Year) 00 Decistorie Cinneture	(5)					TTE 1	O1 CT.TN	TON MARY	I.AND 207	35	
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Physician /Medical Examiner certificate be executed physician and s the burial-trans Box 68760.

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Baltimore, Maryland 21215-0020

Direct

Funeral

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Completed

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Examiner Sequentially list conditions, if any, leading to immediate cause. Enfer Underlying Cause (Disease or Injury that initiated events resulting In death) Last Physician/Medical by Completed

> 25. Was case referred to medical axaminer? 28d. Describe how injury occurred DRIVER OF AUTO THAT WAS SHOT & THEN STRUCK A PARKED AUTO 28f. Location (Street and Number or Flural Floute Number, City or Town, State) WARDEN STREET (SHOT) 27. Manner of Death 5 Pending investigation 1 ☐ Yes 2 ☐ No MAY 21, 1997 2:20 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) XX Homicide AND 3600 BLK. PARK PL. (MVA), STREET

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and see to the caused) and makener as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and fifle of certifier 29c. License number

30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

S.B. HoGauilli, M.D.

8609 2nd Avenue, Suite 404B, Silver Spring, MD

Doo54566

29d. Dale signed (Month, Day, Year)

2/16/00

31. Date filed (Month, Day, Year) State

FEB 2 8 2000

32. Registrar's Signature

Registrar DHMH 16 Rev 6/95

							rtificate d	f Health ar of Death		Re	eg. No.	00	140
Physicia	'n	1. Decedent's Ner	me (First, Middle, La	st)					2	. Dete of Deet Month	h Dey	Yeer 3.	Time of Deeth
/ /Medic	_		nald	Samue1	Jack	kson				eb. 27	, 2000		LO:15 AM
Examin	er	4a Facility Neme	(If not institution, giv	e street and number	9r)			4b. City, Town		tion of Death	4c. County	of Death	
	Ц		Lane Nurs				M I Indea 4 V	Laure1		151	P.G.		
Funeral Director		5. Sociel Security 579 80 1	014	ex 7.	Age (In yrs.	lest birthday) Yrs.	If Under 1 You Months De	ys Hours	Min.	Date of Birth (Month, Day, Oct. 3.	Year)	9. Birthplece Country) Wash.,	Stete or Foreign
ryland		Usuel Residence of 10a. Stete	10b. County			y, Town or Lo							side City Limits
e Ma	cto				Wa	ashing	ton, D.	G.				1	XYes 2 □ No
72 hours after death with the Maryland natural', or Itema 23a or 28a-1 show sical Examination must be not fied at	Funeral Director	2105 32	umber 2nd. Stree	t,S.E.			10f. Zip Coo 200			10	0g. Citizen of V	Whet Country?	
Items i	ner	11. Marital Status		12. Was Decede Armed Force		,S. 13.	Wes Decedent	of Hispanic Orlgi Cuben, Mexican,	n? (Specif	fy Yes or No-		e - American In	dien,
ours after death v sal', or items 23s Examine: mun	by Fu		rried 2 Merrled 4 □ Divorced	1 X Yes 2[If Yes, Give Year or Dete	□No		1 □ Yes 2 🗓				Specify		
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C 1 6	Completed	Elementery/Sec 8th p		College (1-40	or 5+)	life.	ndor	one during most o tired)	r working		Self E	mployee	d
s 1 and 2 should be filed within fleath and Mental Hygiene. Heath and Mental Hygiene. Item 27 is marked other than other traumatic event, item	Be	17. Fether's Neme	(First, Middle, Last)							First, Middle, M	Meiden Sumen	10)	
2 should I and Men is marked aumatic	2	19a. Informent's N	Neme/Relationship (Type, Print)		19b. Mailir	ng Address (St	reet end Number	or Rurel F	Route Number	, City or Town,	Stete, Zip Code	3)
nd 2 uith ai			e C. Jack	**		3426	23rd.	St.,S.E.	Wa	sh.,D.	C. 2002	.0	
0			sposition Cremation 3 5 Other (Specif		0	Plece of Dispo	nsition (Name of New Yorks)	[/] Aª∝Cemeto	ery 3	3/3/00	20c. Location - Quanti	City or Town, S	itete
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		23a. Pert1. Enter	the diseese, or com art feilure. List only	plicetions that caus	sed the deet							App	roximete vel Between
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/Medical Examiner		Immediete Ceuse disease or conditi	ion	e. Live	2	ance	7:					Sa	eval Mon
	16	resulting in death)				or es e consec						1	
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that the death cered by the attending detached for use	Sue			d								1	
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w requires been sign should be	eted									24e. Wes e perform		eveilebl	utopsy findings e prior to tion of cause
has b	hor											of deeth	?
ysician: The lav is certificate has director, page 2										1 □ Ye	es 2000	1 🗆 Yes	2□ No
Physician: this certific ral director,	Be	25. Wes case refe exeminer?		Hospitel:				Othor		Check only on			
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ding h. After fune	Certification:	1 Natural	5 Pending investigation	(Month,	Dey Year)	Injury		Injury et Work? 1 ☐ Yes 2 ☐ N		o. Dogostoe III	or anjury occur		
or Attending I effer death. Director: Affer I in by the fune	fica	2 Accident	6 Could not b	e 28e. Plece of	Injury - At he	ome, farm, sti	reet, fectory, of			f. Location (St	treet end Numb	per or Rural Rou	rte Number,
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To the To the	Me	29b. Signeture and	tive of certifier	is of			(O)	cense number			2/21	d (Month, Dey,	
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(2)		Te L	iress of person who	Sells M	Control (Item	35 T2	Be1	hure	AUG	2. 4	well.	MD2	0707

State Registrar 31. Dete filed (Month, Dey, Year)

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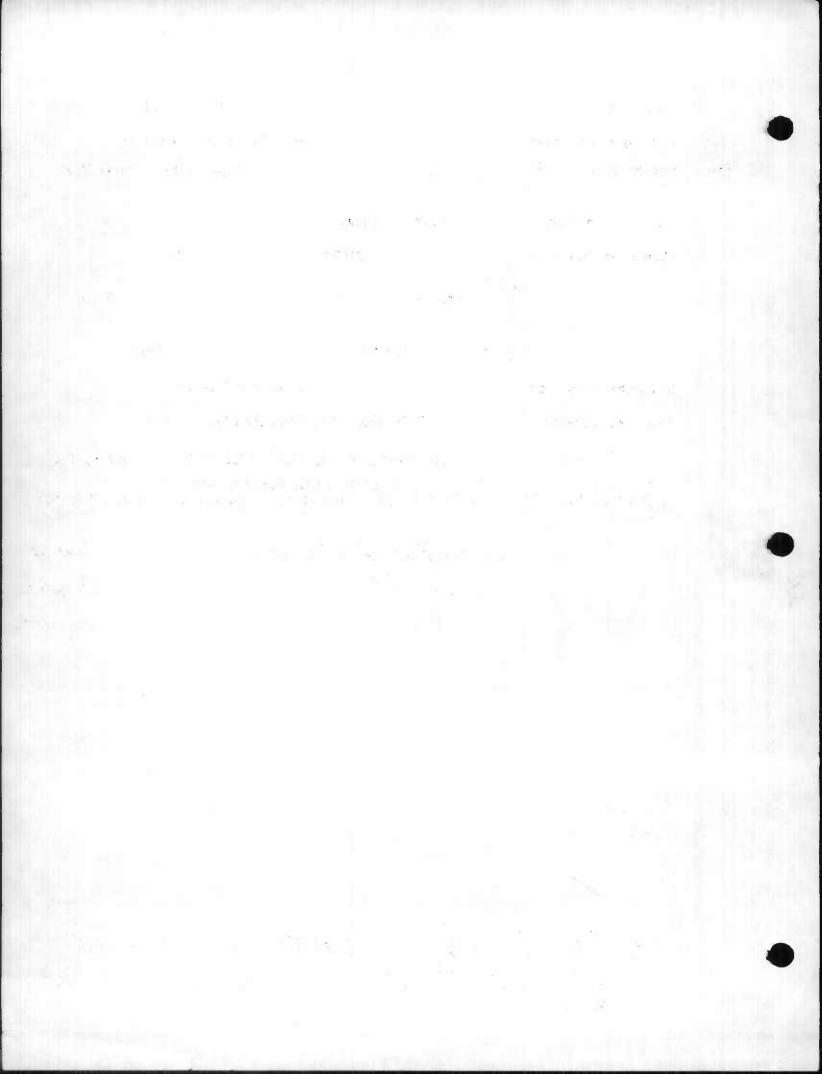
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				Certificate	e of	Death			Reg. N	No.		0 / 10	
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hysician Medical	Peter Jay							Feb.		2000	1 991	8:15pm	
xaminer	4a Fecility Name (If not Institution,	give street end number	er)			4b. City, Tow	vn, or Loc	ation of Deat	th d	c. County	of Deeth		
	1530 Glenville R	oad				Havre	de	Grace	- 1	Harfo	rd		
neral		. Sex 7.	Age (In yrs. lest birth	dey) If Under Months	1 Year Devs	If Under 2 Hours	4 Hrs. Min.	8. Dete of Bi (Month, De	rth ev. Yes	17)	9. Birthp	lece (State or Foreig	n
ctor	109-03-7714 Usual Residence of Decedent	10 X M 2□ F	87 Yr	S.	Doyo	110010		01/05/	191	3		York	
by Funeral Director	10e. Stete 10b. County		10c. City, Town	or Location							11	Od. Inside City Limits	
Director	MD Harfor	d	Havre	de Grad					10g. (Citizen of V	Whet Coun	1 Yes 2 XNo	_
ā	1520 Clamaille 5	and.			078				US				
Funeral	1530 Glenville R	12. Wes Decede	nt Ever in U.S.	13. Was Deced		lispanic Orig	in? (Spec	cify Yes or No		-	e - Americ	an Indien,	
E	1 ☐ Never Merried 2 🕱 Married	Armed Force 1 X Yes 2[If Yes, Give	s? ⊒No				Puerto P	Rican, etc.)		Bled	ck, White,	etc.	
þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Date	s: 1940-45	1 ☐ Yes 2	X No	Specify:				Specify	" Wh	ite	
ted	15. Decedent's	Education	16a. D	ecedent's Usua	Occup	pation		-	16b.	Kind of B	usiness/Inc	dustry	
Completed	(Specify only highest (Elementery/Secondery (0-12)	(1-4c College (1-4c	(1)	Give kind of wor ife. DO NOT us	k done e retire	during most d)	or workin	9					
Eo	Elementery/Secondery (U-12)	4 years		armer						Fari	m		
Bec	17. Fether's Neme (First, Middle, La	st)				18. Mother	's Neme	(First, Middle	, Maid	en Sumen	10)		
To B	Delancey Kane	Jay				Eliza	abet	h More	gan				
	19e. Informent's Neme/Reletionship		19b. N	Aeiling Address	(Street					y or Town,	Stete, Zip	Code)	
	Peter A. Jay- S	Son	P.C). Box	206	, Chu	rchy	ille, I	MD	21028	8		
	20e. Method of Disposition		20b. Pleca of D	isposition (Nen	ne of			Dete			City or To	wn, Stete	
	1 ☐ Burial 2 🕽 Cremetion 3 4 ☐ Donetion 5 ☐ Other (Spe		R.A. F				12/	20/00	Ma	c+ Ck	aneta	ь БА	
	21. Signeture of Funeral Service Lic		Ν.Α. Ι	22. Name an				23/00	we.	St Ci	ieste	, , ,	
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	23a. Part1. Enter the disease, or co shock/or heart failure. List on	malications that saw	NVN TV	123 S.	Was	hingt	on,	Havre	de	Grad	ce, N	D 21078	_
н	shock or heart failure. List on	ly one cause on each	line.	t enter the moo	e or dyn	ng, such as c	argiac oi	respiretory t	arrest,		1	Intervel Between Onset end Death	
	Immediate Ceuse (Finel	^	4	1		0 1					1		
	diseese or condition resulting in deeth)	e (e	ngestu	B she	20	failt	re					6 years	
-			De lo (or es e co	nsequence of):		V						10	
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Physician/	Pert II. Other significant conditions	contributing to death	but not resulting in t	he underlying c	ause giv	ven in Pert I.		23b. Did	tobac	co usa co		the cause of death	
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by											T 041 W	a dana dia tana	-
Completed								24a. Wes	s en eu ormed	topsy	eve	ere autopsy findings elieble prior to mpletion of cause	
ple								1			of	death?	
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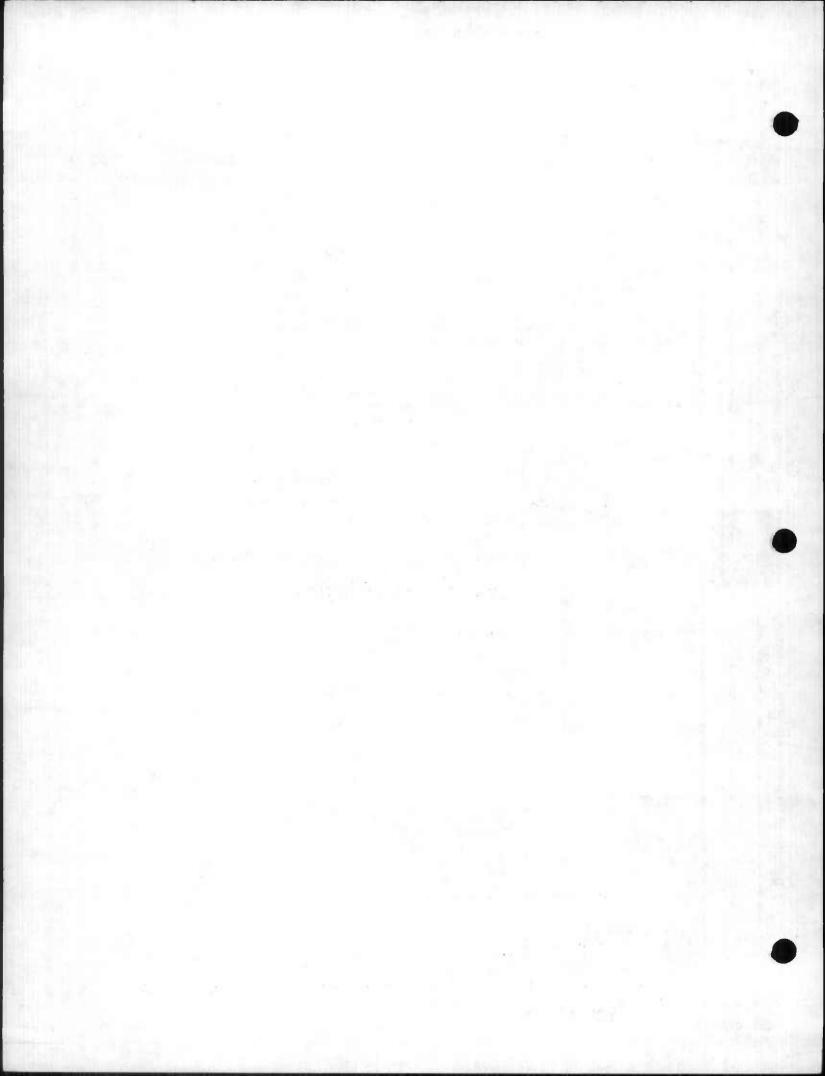
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Phys. PGC 3-3-2000 cr 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Joan 26 2000 **Physician** 1:15 AM Patricia Knott Jean Heb ruary /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctor's Community Hospital Lanham If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) **Funeral** Months Days 577-42-0229 1 M 2 KF Hours Director Washington DC March 31,1932 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. fnside City Limits 28s-f show Greenbelt 1 ☐ Yes 2 ☐ No Director Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 20770 7848 Lakecrest Drive U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Giva Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, ato Never Married 2 Married White 1 Yes 2 No Specify "natural", or Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Hygiena. College (1-4or 5+) Elementary/Secondary (0-12) Secretary Federal Government Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) 8 Pages 1 and 2 should be 1 sent of Health and Mental Elizabeth A. Carroll Adrian D. Knott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health am 27 la 5404 Powhatan Road Riverdale Maryland 20737 Barbara Davis (Sister) 20a. Method of Disposition 20b. Ptace of Disposition (Name of cematery, crematory or other p 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery March 1,2000 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intarval Between Onsat and Death **Physician** i days frmmediate Cause (Finat disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last The law requires that the death certificate be assec-Box 68760. Physician/Medical Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death, but not resulting in the underlying causa given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2000 3 Probably 4 Unknown 110 Division of Vitai Records, þ 24b. Wera autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? N/A 1 ☐ Yas 1 ☐ Yes 25. Was case referred to medical examiner? 8 26. Place of Death (Check only ona) Hospitat: 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 200 1 [Impatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation Attanding 1 Naturat To the Funeral Director: Al completely filled in by the fu 1 Tyes 2 Who 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 8 Cortifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29d. Date signed (Month, Dgy, Year) 29b. Signature and titla of certifier

State Registrar

DHMH 16 Rev 6/95

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32. Registrar's

30. Nama and address of person who completed causa of death (item 23a) (Type, Print)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08749 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Tima of Deeth 2. Date of Death Month 2-18-2000 Karl Mathew Kagan 10:32 am 4b. City, Town, or Location of Death Silverspring 4a Facility Name (If not institution, give street and number) 4c. County of Death Montgomery 8103 Eastern Ave If Under 1 Year Months Days 7. Age (In yrs. last birthday) If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 2-19-1917 9. Birthplace (State or Foreign Massachusetts 027-01-7518 10XM 2□ F Hours Usual Residence of Decedent 10a. State MD Montgomery 10c. City, Town or Location t0d. Inside City Limits 1 ☐ Yes ¾ No Silverspring 10f. Zip Code 20012 10e Street and Number 10g. Citizen of What Country? 8103 Eastern Ave USA 14. Race - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2€No Specify: 3 ☐ Widowed 4 Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Retail Salesman vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Stanley Kagan Maria Chwatek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Manhan Rd South Hampton Mass Buckley Elaine 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, Stete St Stanislaus 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 2-22-00 E. Hampton Mass 4 Donation 5 Other (Specify) 22. Name and Address of Facility O'Brien Funeral Home 21. Signature of Fameral Service Liceon 17 Clark St East Hampton Mass 01027 complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset end Deeth Immediete Cause (Final disease or condition resulting in death) Carcinoma Of Larynx Due to (or as a consequence of). Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did lobacco usa contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Hypertensive Cardio Vascular Disease 24a. Wes en autopsy performed?

Physician /Medical Examiner

The law requires that the death certificate be asscuted

P.O. Box 68760,

Records,

Division of Vital

Physician

/Medical

Examiner

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Completed

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Funeral

Director

r than "natural", or items 23a or 28a-f ahow the Medical Eservines must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: If them 27 is marked other than "natural", or hen eny injury or other traumatic avent, the Medical Essentian page.

Baitimore, Maryland 21215-0020

the Maryland

death

Physician/Medical by Completed Be

Examiner edical Certification: To

attending physician and for use as the buriai-transit signed by the a page 2 s toaptat or Attending Physician: The Abours after death.

"unerel Director: After this certificate ely filled in by the funeral director, pe

To the Hospital within 24 hours a To the Funeral C completely filled

State Registrar

24b. Were eutopsy lindings available prior to completion of cause of deeth? 1 Yes ZENo 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) ¥ Yes 2□ No Other: 4 Nursing Home 5 № Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation Natural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Addical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, end due to the cause(s) and manner stated. 29a. Certifier

29b. Signature and little of certifier MO OME

29c. License number D 00428 29d. Date signed (Month, Day, Year) Feb 18,2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Park Dr Silverspring Md 20902 2101 Iran Brecher MD OME

31. Date filed (Month, Day, Year)
MAR 0 1 2000

32. Registrar's Signature

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MAR 9 1 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death Month Florence Kahlert Mae 2000 March 1340PM 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | ff Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Days 1 M 2 X F Yrs. January 20,1911 Washington Usual Rasidenca of Dacedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1⊠ Yes 2□ No Maryland Montgomery Rockville 10g. Citizen of Whal Country? 10f. Zip Code 9701 Viers Drive U.S.A. 20850 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ Xo If Yas, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Nevar Married 2 Married 1 Yes 2 No Specify: White 3√Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Eiamentary/Secondary (0-12) College (1-4or 5+) Clerical Washington Gas 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) C. Graves Hallie Burke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arnold Graves (Brother) 7032 Dover Avenue Rose Haven Maryland 20714 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, Stata March 6,2000 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery Arlington VA 21. Signatura of Funer Servi 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Part1. Enter the disease, or complications that ceusad tha death. Do not enter tha moda of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one causa on each line. Approximata Interval Between Onset and Death -don Due to (or as a consaguanca of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or Injury Dua to (or as a consequence of): Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yas 1 Yas 2 No 25. Was casa rafarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dala of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Tima of 28c. Injury al Work? 5 Panding 1 ☐ Yes 2 ☐ No investigation 6 Could not be 28e. Placa of Injury - At homa, farm, straal, factory, office building, atc. (Specify) Location (Streat and Number or Rural Routa Number, City or Town, State)

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician:

Examiner attending physician and for use as the bunal-transit been signed by the should be detached his certificate has buildirector, page 2 s this funeral After efter deeth Director: • Funeral Dire letely filled in b

Physician

/Medical

Examiner

Funeral

Director

the Maryland

permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health end Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any fujury or other traumatic event, the Medical Examples must be notified at page.

Physician /Medical

Baltimore, Maryland 21215-0020

5. Social Security Number

577-20-5024

10e. Street and Number

12th

Immediata Cause (Finai

Ihat initiated avents rasulting in death) Last

axaminar?

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Cartifiar

4 Homicida

(Check only one)

1 Yes 2 No

disease or condition rasulting in death)

11. Maritai Status

Walter

10a. State

Directo

Funeral

by

Completed

2

Physician/Medical Examiner

P

Completed

Be

Certification: To

Medical To the Hosp within 24 ho To the Fune completely fi

Registrar

29b. Signature and title of cartifiar Robert

29c. License number

29d. Dale signed (Month, Day, Year)

30. Name and address of person who completed causa of daath (Itam 23a) (Typa, Print)

Shady Grove Rd. Swife 201

01 Kockville

31. Date filed (Month, Day, Year) MAR 0 3 2000

1🗹 Certifying Physician: To tha bast of my knowladga, daath occurred at the tima, date and place, and due to tha causa(s) and mannar as stated.

2 Medical Examinar: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

40A B 3 2000 Brown & Special

State of Maryland / Department of Health and Mental Hygiene	00)	0	8	7	5
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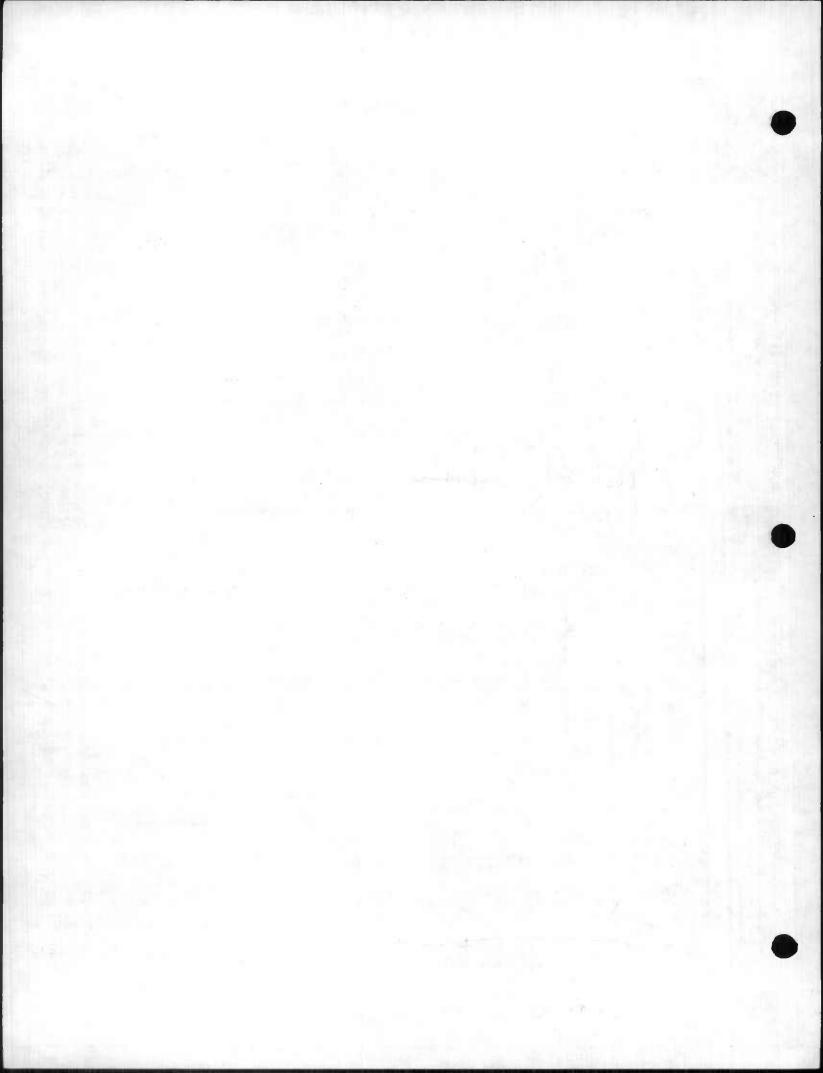
Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 9:52 PM LOTTIF LEGGETT March 1 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Center Clinton 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ■ M 2 X F 291-32-1087 74 Director Oct. 4, 1925 Germany Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inaide City Limita Maryland Charles Waldorf 1 ☐ Yes 2 No Director 10f. Zip Code 20603 10e. Street and Number 6027 New Forest Court #6 10g. Citizen of What Country? must be n Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forcea? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yas 2 🕅 No If Yes, Give Year or Dates: Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) filed within 72 London Fog Elementery/Secondary (0-12) Collega (1-4or 5+) Manufacturer Seamstress 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Mental Nichelas Kalaschnikow Margarete Besteck Pages 1 and 2 should Department of Health and Mi Important: If them 27 is man any injury or other traumeti anno. 19a. Informant's Hama Politionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Leggett/Husband Michael A. 6027 New Forest Court #6.Waldorf, Maryland 20603 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Dispositio 1 D Buria 2 X Cre Huntt Crematory 03-08-2000 Waldorf, Maryland ²²The Huntt Funeral Home, Inc. MARK G: BROHAWN P.O. Box 156, Waldorf, Maryland M00053 mew 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trai P.O. Box 68760, Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No Division of Vital Records, Be Completed by funeral director, page 2 should be 24b. Were autopsy findings evallable prior to completion of cause of death? 24a. Was en eutopsy 2 No this certificate 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) examinet? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Mennes of Deeth 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No invastigetion 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner atated. 29a. Certifier 29b. Signatura and title 29d. Date signed (Month, Day, Year) 29c. License number lodd ym 30. Name and address of person who completed causa of death (item 23a) (Type, Print) M.D 31. Days filed (Month, Dey, Year) 32. Registrar's Signature

State Registrar

MAR 06



Please Type or Print In Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middla, Last) 2. Data of Death 3. Tima of Death ookabil Day **Physician** Month Year Sylvia February25,2000 11:35 AM /Medical 4a Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4000 William Lane Prince Georges Bowie If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (Stata or Foreign Country) **Funeral** Days Months Hours 1□M 20 F Yes 73 March25,1926Pennsylvania Director 579-26-1470 Usual Rasidence of Decedent 10b County 10c. City, Town or Location 10d Inside City Limits show 1 Yes 2 No Director 28s-f Prince Georges Bowie 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 4000 William Lane 20715 USA Funeral natural, or itsms Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, Whita, etc. 1 Yes 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry United States Hygiene. Elemantary/Secondary (0-12) Collega (1-4or 5+) Government 12 Secretary 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) 88 Pages 1 and 2 should be nent of Health and Mental is marked creamant ev C Esau Harry Bessie Mendlowitz 19e. Intorment's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) artment of Health a ortant: if Item 27 is injury or other tra Lloyd E. Lookabill/Husband 4000 William Lane Bowie, Md. 20715 20b. Place of Disposition (Name of cemetary, crematory or other place)
Fort Lincoln
Cemetery 20a, Mathod of Disposition Data 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Ramoval from Stata 4 ☐ Donation 5 ☐ Othar (Specify) 02-29-00 Brentwood, Maryland 21. Signatura of Funerel Sarvice Licensee 22. Name and Address of Facility Beall Funeral Home Shannon W.B Shannon W. Beall M00798 6512 N.W. Crain Hwy. Bowie, Md. 20715 23a. Part1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Causa (Final nemonia 5 days diseasa or condition resulting in daath) Examiner Dua to (or as a consequence of): Physician/Medical Examiner Hepatic Encephalopath week be executed ician and burial-trans Sequentially list conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disaase or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): physician s the burial Metastatic Box 68760, Lmonth Dua to (or as a consequence of): 2010 Cancer 1 CON Part II. Other algorificant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 20 No 3 Probably 4 Unknown ate has been signed by page 2 should be detac Records, by 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yas 2 ☐ No certificate Division of Vital Hospital or Attanding Physician: 25. Was casa referred to medical axaminar? Be 26. Place of Death (Check only one) Other: 4 Nursing Homa Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 1 Yas 50 Residence 6 Other (Specify) this 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Natural 5 Pending invastigation 1 ☐ Yas 2 ☐ No will in 24 hours after death.

To the Funeral Director: A 2 Accidant 6 Could not be determined 3 Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homlcide Certifying Phyalcian: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mennar stated. edical 29a. Cartifiar å 29b. Signeture and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 2 Canine werry, m/ 25,2000 30. Nama and address of person who completed cause of death (Item 23a), (Type, Print) Werner, Road, Six K 300, Annapolis, MI) 21401 900 Jeanine 32. Registrar's Signatura 31. Date filed (Month, Day, Year)
FEB 2 8 2000 State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death Physician Jean Ellen Laws 21, ZUUU 4c. County of Death Feb /Medical 10:30AM 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Southern Maryland Hospital Center Prince Georges Clinton If Under 24 Hrs. 5. Social Security Number If Under 1 Year 8. Data of Birth (Month, Day, May 4, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10M 20F Months Days Hours Yrs. Director Wasington DC 578-20-2976
Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Director Prince George Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1 and of health and Mental hygienn.

Int: if item 27 is marked other than "natural", or frems 23a or inty of other traumatic avant, the Medical providence in all health in the control of the providence in all health in the control of the providence in all health in the control of the providence in all health in the control of the providence in all health in the control of the providence in all health in a period of the providence in all the control of the providence in a providence in a period of the period United States 6707 Birch Lane Funeral 20748 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary 12 P.G. Board of Education 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Be George F. Cox Mary Hook 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James William Laws (Husband) 6707 Birch Lane, Temple Hills, Maryland 20748 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Feb. 28, Buriat 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) permit. Page Department of Important: If any injury or once. Maryland Veterans Cemetery 2000 Cheltenham, Maryland 22. Nama and Address of Facility Lee Funeral Home, INC. 6633 Old Alexander Ferry Rd. Clinton, Md. 20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Hyperfensi on /Medical Examiner Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burlat Box 68760, Physician/Medical Due to (or as a consequence of): USB Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1☐ Yes 2☐No 1 ☐ Yes 2 ☐ No Division of VItal Hospital or Attanding Physician:
24 hours after death.
 Funeral Director: After this cartific funeral director, 8 25. Was case refarred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Unpetient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2□ No Certification: To 27. Manner of Death 28d. Describe how injury occurred 28b Tima of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 1 Natural
2 Accident 1 Yes 2 No 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certified 29c. License number 29d. Data signed (Month, Day, Year) Besienico

Registrar

FEB 2 8 2000

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) and menner as stated.

**Medical Examinar: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29b. Signature and title of pertiner 29c. License number 29d. Date signed (Month, Day, Year) OCME MARCH 7, 2000

rson who completed cause of death (Item 23a) (Type, Print) 30. Name an

tane[111 Penn Street, Baltimore, Maryland 21201

State Registrar

Medical

MAR 13 2000 31. Dafe filed

Regisfrar's Signature Dock.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3 Time of Death MARCH ETHEL LOVIE RAYMOND LAWRENCE 8:20 AM 4a. Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death BURCHWOOD GROUP HOME #2 ACCOKEEK PRINCE GEORGES 8. Data of Birth (Month, Day, Year) 6. 1905 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Sacurity Number 7. Aga (In yrs. last birthday) Birthpiaca (State or Foreign Country)
 MARYLAND 10 M 2 F Months 216-05-9775 95 Yrs. Usuai Rasidance of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits Was 2□ No MARYLAND PRINCE GEORGES FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 13003 JACKSON DRIVE 20744 UNITED STATES 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ No if Yas, Giva Yaar or Datas: 13. Was Dacedant of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Marital Status 14. Race - Amarican Indian. Black, Whita, atc. 1 Navar Marriad 2 Married 1 Yas 2 No Specify: BLACK 3 → Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT usa retired) 15. Decadant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8TH GRADE HOUSEWIFE NOT APPLICABLE 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maidan Sumama) FRANK RAYMOND EDMONIA DYSON RAYMOND 19b. Mailing Addrass (Straat and Numbar or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ALICE GRAY / NIECE 6580 POMFRET ROAD, LA PLATA, MARYLAND 20646 20b. Placa of Disposition (Nama of cematery, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 4 Donation 5 Other (Specify) METROPOLITAN CHURCH CEM. 3/9/00 POMONKEY, MARYLAND 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640
Approximate the morte of dving, such as cardiac or respiratory arrest,
Approximate trigging Rehypering 23a. Part 1. Enter tha disaasa, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Interval Batween Onset and Death Immediata Causa (Final ENFARCTION disaasa or condition rasulting in daath) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disease or injury that Initiated avants resulting in death) Last Dua to (or as a consequence of) Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? 1 ☐ Yas 2 No 1 ☐ Yas 2 No 26. Placa of Daath (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Rasidance 8 Other (Specify)

Physician /Medical Examiner

physician

The law requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vital

Physician

/Medicai

Examiner

Funerai

Director

28a-f show

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permit. Peges 1 and 2 should be filled within 7. Department of Health and Meniel Hygiene. Important: if item 27 is marked other than "na any injury or other traumatic event, the Weds. once.

Director

Funeral

by

Completed

Be

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traumatic event, the Medical Examiner must be notified at

the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0020

Physician/Medical ettending for use es signed l by should should Completed il director, page 2 s To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be P Certification:

Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 25. Was casa rafarred to medical axaminer? 1 ☐ Yas 2 No 27. Mannar of Daath 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Panding 1 Yas 2 No invastigation Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) MAIAM 2 Accidant NJA 6 Could not be 3 Suicida 281. Location (Straat and Number or Rural Routa Number, City or Town, State) 4 Homicida NIA 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifiar (Check only one)

State Registrar

Medical

E. HERRY VICTOR 31. Date filed (Month, Day, Year) MAR 07 2000

29b. Signatura and titla of certifian

M. D 32. Registrar's Signatura Deneva

30. Name and address of person who complated cause of death (Item 23a) (Type, Print)

9131 PISCATAWAY

29c. Licansa number

120986

29d. Data signad (Month, Day, Year) 3-6-2000

Rd CLINTON MD 20735

When E. Hongwig Dansel

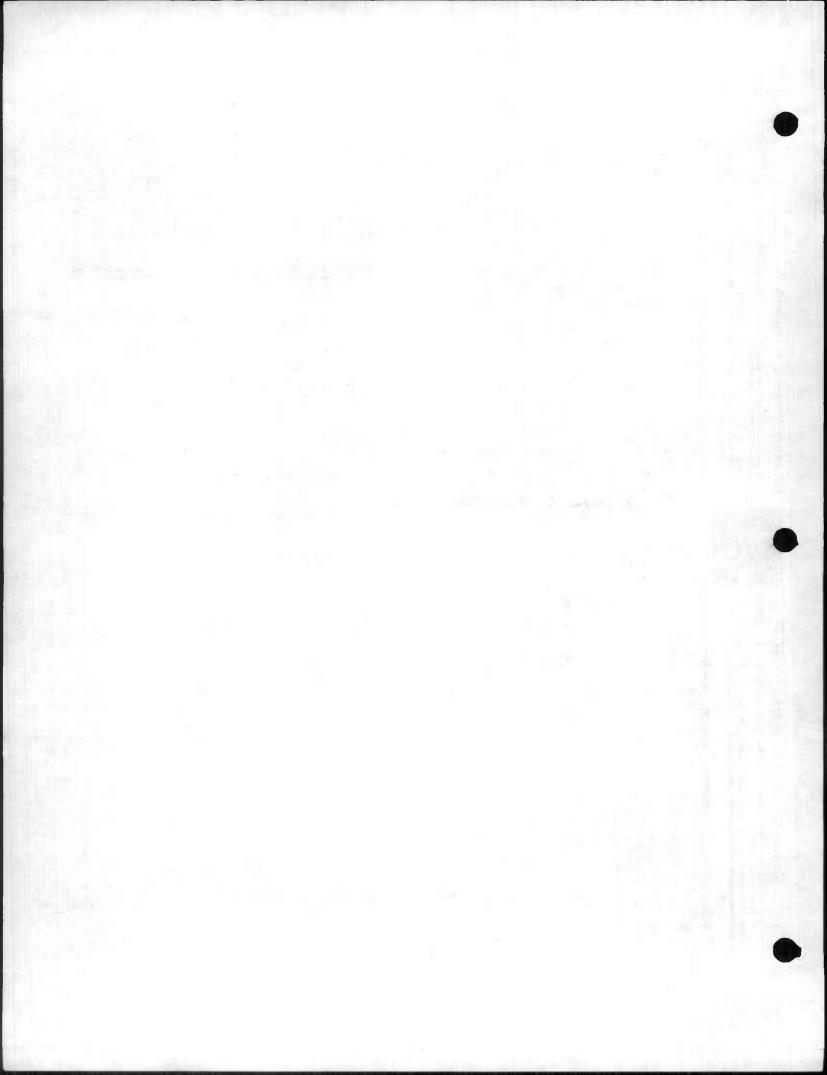
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dale of Death 3. Time of Death MARCH 1, Physician 2000 11:35 AM MARY LAMBERT /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) June 21, 1921 Birthplace (State or Foreign Country) **Funeral** Months Days 1 M 2 D F Hours 78 217-18-8385 Yrs. Maryland Director Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or hama 23a or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No Maryland Carroll Keymar Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6945 Middleburg Rd. 21757 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11 Marital Status 72 hours after 1 Yes 2 No
If Yes, Give
Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White g 3 2 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 7 Hyglens. Other then "n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hygien importants if flem 27 is marked other the any Injury or other traumatic event, the 2008. homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Sumame) 99 Ezra A. Wetzel Fannie Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward A. Lambert, Jr./ son 6945 Middleburg Rd. Keymar, MD 21757 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 XBurial 2 Cremation 3 Removel from Stete Linganore Cemetery 3/6/00 Unionville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Hartzler Funeral Home 21. Signature of Funeral Service Licent 6 E. Broadway Union Bridge, MD 21791 Marine 23a. Part1. Enter the disease, or complications that cau and the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each min. Approximate Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) ACUTE MYULMOIAL MINUTES Examiner Due to (or as a consequence of): Examiner MITERY YEARS DUFFAIF CORONANY physician and the burlai-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): 089 P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tohacco use contribute to the cause of death? of the signed by t 1 Yes 2 No 3 Probably 4 Unknown Records. þ been si Completed 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? paga 2 s 1 ☐ Yes 2 No 1 Yes 2 No certificate Division of Vitai Attending Physician: 25. Was case referred to medicat examiner? Be 26. Place of Death (Check only one) Hospitet: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpetient 3 DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Afferi 5 Pending 1 Naturat To the Hospitat or Attendit within 24 hours after death. To the Funeral Director: At completely filled in by the fu death. 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifie PA 03-07-2000 MODIST67E 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Ronald Krablin 423 S. Washington St. Gettysburg, PA 17325 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

MAR 0 2 2000

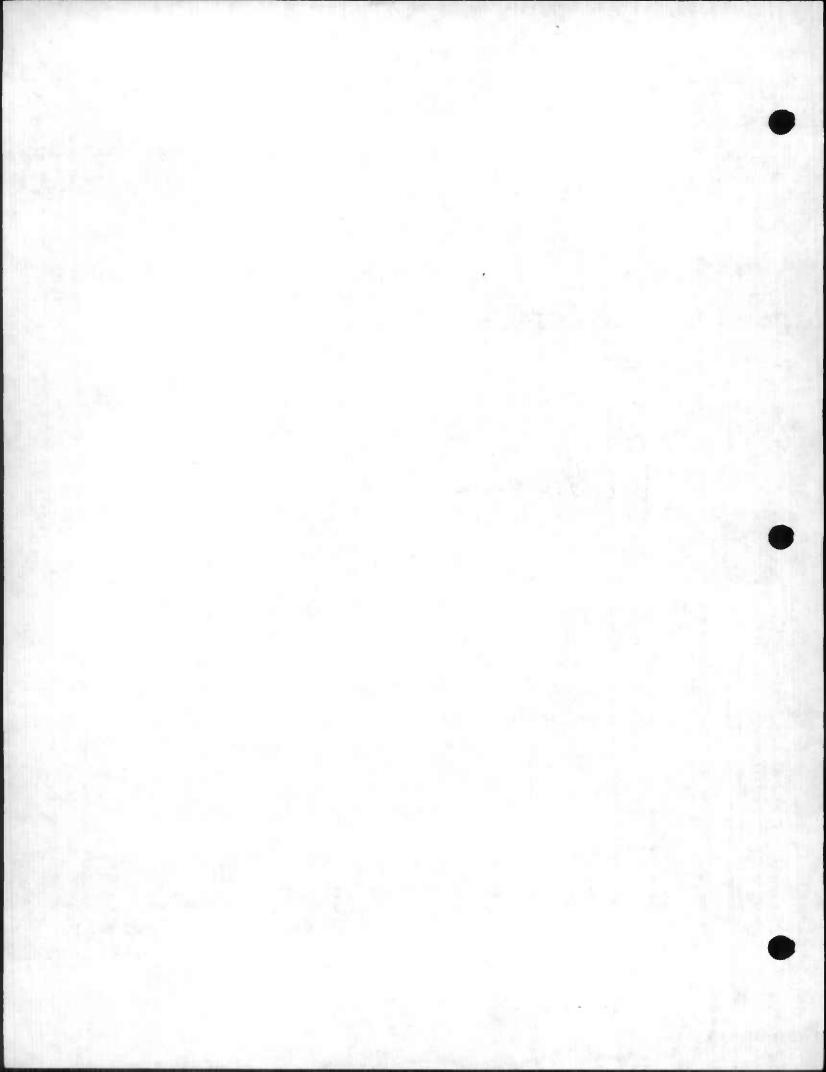


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Tima of Death Day **Physician** SHIRLEY ROSE MCDERMOTT MARCH 3,2000 01:49 /Medical 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Calvert Memorial Hospital Prince Frederick Calvert 5. Social Security Number 8. Dala of Birth (Month, Day, Year) April 11,1940 9. Birthplaca (Stata or Foreign Country) Virginia 7. Aga (In yrs. last birthday) **Funeral** 10 M XXF Months Hours 577-54-2392 59 Yrs. Director Usual Rasidanca of Decedant the Meryland permit. Peges 1 and 2 should be filed within 72 hours efter death with the Menfar Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28s-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. Stete 10h County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5904 Michael Road 20601 U.S.A. Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-it Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. 11. Marital Status Black, Whita, etc. 1 □ Nevar Marriad 2 □ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: specify: White þ 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupetion 15. Decedent's Education (Specify only highast grada completed) 16b. Kind at Business/Industry (Giva kind of work dona during most of working lifa. DO NOT usa retired) Elementery/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 18. Mother's Nama (First, Middla, Maidan Sumama) 17. Father's Name (First, Middla, Last) Viola V. Taylor Everett Ronk 19e. Informant's Neman Palationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Code) Jowana Wallich/Daughter 5801 Park Drive, Bowie, Maryland 20715 20b. Place of Disposition (Nama of camatary, cramatory or other place) Dela 20c. Location - City or Town, Stata 20a. Malhod of Disposition 1 Bulial 2 □ Crem Ft. Lincoln Cemetery 03-07-2000 Brentwood, Maryland 4 Donetion 5 Domer Spy Signature of Furnant Segroot 22. Name and Addrass of Facility
The Huntt Funeral Home, Inc. P.O. Box 156, Waldorf, Maryland BROHAWN 20604 mew G. M00053 23a. Pert∜ Enter the diseasa, or complications that caused the deeth. Do not antar tha moda of dying, such as cardiac or raspiretory arrest, shock, or haart failura. List only one cause on each line. Approximate Intarval Between Onsat and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in death) /Medical 48 hours Myocardial Examiner Due to (or es a consequence of): Examiner the attending physicien and hed for use as the bunal-transit Sequentially list conditions, if any, leading to immadiate cause. Entar Undarlying Cause (Disaase or Injury Dua to (or as a consequence ot) licate be execu 68760 Physician/Medical thet initiated evants rasulting in death) Last Due to (or as a consequence of): Box PO 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 1 Yea 2 No 3 Probably 4 Unknown yd bengis Diabetes Mellitus Division of Vital Records. 2 24a. Wes an autopsy performed? 24b. Wara autopsy tindings aveilable prior to Completed completion of causa of deeth? certificate has 1 Yas 2 No 1 Yas 2 No ours after deeth.

eral Director: After this certific filled in by the funeral director, 25. Was case retarred to medical examiner? 8 26. Placa of Daeth (Check only ona) Hospital: Other: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No 1 Inpaliant 70 2 ER/Outpetient 3 DOA 28a. Deta of Injury (Month, Day Year) 27. Menner of Deeth 1 Natural 28b. Tima ot 28c. Injury at Work? 28d. Describe how injury occurred Certification: il or Attending F 5 Pending investigation 1 Yas 2 No 2 Accidant 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide 6 ☐ Could not be 28a. Plece of Injury - Al homa, farm, street, fectory, office building, atc. (Specify) 4 ☐ Homicida Hospital of 24 hours at To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier Medical completely 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signatura and titla ot certifian 00 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) CATHERINE BROPHY, MD DUNKIRK, MD 20754 31. Data filed (Month, Day, Year) 32. Registrar's Signatura State MAR 06 2000 Tener Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Shirley Marceron 29, 6:50 P.M. Feb. 2000 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Southern Maryland Hospital Center Clinton 7. Age (In yrs. last birthday)
58 Yrs. 5. Social Security Number 6. Sex If Under 1 Ye ar If Under 24 Hrs. Birthplaca (Steta or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 2\ F Months Days Hours Director Jan.12, 1942 Washington, D.C. 579-54-7954 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c City Town or Location 10d. Inside City Limits ns 23a or 28a-f ahow man be notified at 1 ☐ Yes 2 No Director Lothian Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 216 Ella Welch Way 20711 U.S.A. Funeral Hems ? 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ② No if Yes, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status th and Mental Hygiene. 7 is marked other than "natural", or item traumatic avent, the Mental Exertions. Black, Whita, etc. filed within 72 hours after 1 Never Married 2 Married specify: White Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) . Pages 1 and 2 should be file ment of Health and Mental H-lant: If item 27 is marked oth lury or other traumatic aven Be Bettie Mellisa John Henry Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 435 Dutch Dr., Lothian, MD.20711 Lisa L. Marceron/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1XXBurial 2 Cramation 3 Removal from State permit. Page Department of Important: If any injury or 3/4/2000 Suitland, MD. Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. alas 6160 Oxon Hill Rd. Oxon Hill, MD. 20745 23a. Part 1. Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disaase or condition resulting in deeth) Examiner Examiner wellownyopat The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of): Box 68760, revious MIYO cara las Physician/Medical the Due to (or as a consequence of) signed by the attending p ymla Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Dercholy Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate has 1 Yes 2 No 1 Yas 2 No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Unpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 25 No 27. Menner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending 1 DNatural ne Hospital or Attending in 24 hours after death. he Funeral Director: Afte 1 Yes 2 No investigation 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiar To the Hosp within 24 ho To the Fune complately fi (Check only one) 29c. License number 29b. Signature and title of certifier (W)

State Registrar

MAR 0 2 2000

Eda

31. Data filed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 My 7700 Old 8 32 Registrar's Signature

MAR 2 2 2000 Secret 1 County

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day February 27/00 ocation of Death 4c. Country of Death MARSHALL 200 4b. City, Town, or Location of Death 4e Fecility Neme (If not institution, give street end number) Prince George's Hospital Center Prince George's 7. Age (In yrs. lest birthdey) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours Min 1□ M 200 F Yrs. 8- 28- 1948 Wash., DC 10b. County 10c. City, Town or Location 10d. inside City Limits 1 No Yes 2 No Prince George's Lanham 10f. Zip Code 10g. Citizen of What Country? 6807 Gairlock Place 20706 USA 13. Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 12. Wes Decedent Ever In U,S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No Specify: **Black** Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Albritton Receptionist Communications 18. Mother's Name (First, Middle, Maiden Surneme) 17. Fether's Name (First, Middle, Last) Robert Ridley Delores Marshall 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Albert Marshall/Husband 6807 Gairlock Place, Lanham, MD 20b. Place of Disposition (Name of cometery, cremetory or other placa) Dale 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 3/2/2000 Maryland National Cemeter 4 ☐ Donation 5 ☐ Other (Specify) Laurel, MD 22. Name and Address of Facility Tyrone J. Young Funeral Services 719 Kennedy Street, NW Wash., DC shock, or heer feilure. List only one ceuse on each line. 20011 Approximete interval Between Onset and Death zy hour 6 mos breast concer tastatec Due to (or as a consequenca of): Due to (or es e consequenca of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably AUNknown 1 Yes 2 No metastases 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy metastases 20 breast Carres 1 Yes 25 MG 1 □ Yes 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, end due to the cause(s) and manner as ataled.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(a) and manner stated.

Physician /Medical Examiner that the death certificate be executed

P.O. Box 68760,

Division of Vital Records.

or Attending Physicien:

Physician

/Medical

Examiner

Funeral

Director

r 28a-f show

Examiner must be

"naturel", or

nd 2 should be filed within 72 hou alth end Mental Hygiene. 27 ie marked other than "naturel r treumatic event, the Medical E.

permit. Pages 1 end 2 st Department of Health end important: If item 27 ie m any injury or other treum pnce.

Director

Funeral

by

Completed

Be

the Maryland

72 hours after death

Baltimore, Maryland 21215-0020

JOYCE

10a State

5. Sociel Security Number

579-64-8498

10e. Street and Number

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or Injury Ihat initiated events resulting In death) Last

examiner?

1 Matural

2 Accident

3 Suicide

29e. Certifler (Check only one)

4 Homicide

29b. Signature and title of certifier

disease or condition resulting in deeth)

Usual Residence of Decedent

Examiner physician and the bunal-transit Physician/Medicai 88 signed by the a by Completed peen s certificate has t director, page 2 s director. Be Certification: To this After

funeral death. ofter death Director: A

24 hours eff Funerei Di stahy filled in Medicai To the å To the within

Registrar

29c. License number D23743 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

MACTIN D, WEXTZ TSZS G1664 7525 Greenway CT On greenheld MD 20 720 31. Date filed (Month, Day, Year)

MAR 0 2 2000

32 Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure Ali Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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				-	4	0	

			Ce	TITICE	ite of	Death	100		Reg. No.			
1. Decedent's Name (First, Middisician	fle, Last)							2. Date of De Month	eath Day	Year	3. Time	of Death
Susan E.	Matisl	ka						March	1	2000	9:59	a.m.
niner 4a Facility Name (If not institution	on, give street and nur	n <i>ber)</i>				4b. City, Tow	vn, or Loc	ation of Deal	h 4c. C	ounty of Death		
3940 Bexley Pl	ace #508					Suit1	and		Pr	ince Ge	orge	S
5. Social Security Number	6. Sex	7. Age (In yrs.	. last birthdey)		ler 1 Year	If Under 2	24 Hrs.	8. Date of Bi (Month, D				e or Foreig
368 05 8991	1 □ M 2√2 F	88	Yrs.	Month	s Days	Hours	Min.	Septem	ber9.	1911 Ad	lrian,	PA
Usual Residence of Decedent		00										
10a. State 10b. Count			ity, Town or Lo	ocation	130	VETT .					10d. Inside	City Limits
Maryland Princ	e George's	s Su	itland								1 (3KY	as 2 No
Maryland Princ				106.7	Zip Code				10n Citize	on of Whet Cou	intry?	
3940 Bexley Pl	200 #508			10	207	71.6			US		,	
11. Marital Status	Armed Fo		J,S. 13.	Was Dec	pecify Cub	tispanic Ong an, Mexican,	Puerto R	cify Yes or Notican, etc.)	0- 14	Black, White		
1 Never Married 2 Ma	If Yes, Giv	2€ No		1 Yes	2 TrNo	Specify:			S	pecity: Wh	ite	
3 □XWidowed 4 □ Divorce	d Year or D	ates:					11			, , , , , , , , , , , , , , , , , , ,	11.00	
15. Decede	nt's Education		16a. Dece	dent's Us	sual Occup	ation	of workin	0	16b. Kind	of Business/in	ndustry	
Elementery/Secondary (0-12)	College (1	-4or 5+)	(Give kind of work done during most of life. DO NOT use retired)									
12th			Но	Housewife				Privat				
17. Father's Name (First, Middle	, Last)					18. Mother	r's Name	(First, Middle	, Maiden S	umame)		
Unknown Knopic	k						Susar	n Unkn	own			
19a. Informant's Name/Relation			19b Maili	na Addre	ss (Street					Town, State, Zi	ip Code)	
Diane Adkins/d	laughter	120h	Place of Dispo			Road	rt.	. wasn		n, MD 2		
20a. Method of Disposition 1 🖾 Burial 2 🔲 Cremation	3 Pemoval from	State	cemetery, crea	matory o	r other ple		1				own, State	
4 □ Donation 5 □ Other (ery	3-6-00 Verona, PA									
21. Signature of Funeral Service Licensee // 22. Name and Address of Facility												
Juawara & Blayfon 4308 Suitland Road Suitland, MD 20746												
23a. Part1. Enter the disease, of	Approxir	nete										
shock, or heart feilure. Lis	Interval	Between nd Death										
												o Douil
Immediate Cause (Final disease or condition		ARTERO	SCLERO	TIC	CARD	LOVASC	ULAR	DISEA	SE		YRS.	
resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (or as a consec	quence o	1):	1.199						
manet en												
Sequentially list conditions.	В.	Due to (or es e consec	quence o	f):							
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury												
Cause (Disease or injury that initiated events	С	Due to (or as a consequence of):										_
Cause (Disease or injury that initiated events resulting in death) Last		Due to (or as a consequence of):										
	d											
Part II. Other significant conditi	ons contributing to de	eath but not res	sulting in the u	inderlying	cause giv	ven in Part I.		23b. Did	tobacco u	se contributa	to the cau	e of death
Company to the same								1	Yes 2K	No 3 Pr	obably 4	Unkno
							_					
A COLUMN TO SERVICE AND ADDRESS OF THE PARTY								24a. Wa	s an autops	y 24b. V	Vere autop	sy finding
								pen	OIIIIO	C	ompletion f death?	
									- TD			
									Yes 2X	NO 1	☐ Yes :	LI No
25. Was case referred to medical axaminer?					0"	120		(Check only				
1 Yes 2 No		· -	ER/Outpatie			4 LI NUI				Other (Spec	ify)	
27. Manner of Death 1 Natural 5 Pendi	28a. Date (Mont	of Injury th, Day Year)	28b. Time o	f	28c. Injui	ry at rk?	2	8d. Describe	how injury	occurred		
	igation			М	1 🗆	Yes 2 1	No					
3 Suicide 6 Could	nined 286. Place	of Injury - At h	ome, farm, st	reet, fact	ory, office		2			Number or Ru	rel Route N	umber,
4 Homicide	Duildi	ng, etc. (Speci	iry)					City of 10	wn, Stete)			
29a. Certifier 1 X Certifyi	ng Physician: To the	hest of my kni	owledge deat	p occurre	d at the ti	me dete end	d place a	nd due to the	causa(s) a	nd manner as	stated	
	Examiner: On the be	asis of examina										e(s)
	1	ier stated.			On Lineau	no oumbor			20d Date	sinned (Month	Day Yes	r)
29b. Signature and title of continu	1			4	9c. Licens					signed (Month	, Day, 188	,
//	70				DIS	9431				3/2/00		
30. Name and address of person	who poleted caus	e of death (Ite	m 23a) (Type,	Print)								
DR. FRANK RY	11		STON R		#203	FT	MACH.	INGTON	, MD	20744		
31. Date filed (Month, Day, Year	Tree.	egistrar's Sign	100000000000000000000000000000000000000		~~~				,			
1100 00 20	The second secon		-									

MAR 0 2 2800 Same & State

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physician /Medical Examiner

Director

Funeral

à

Completed

Be

NOWALL WHITFIELD MACON 4a Facility Neme (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL

4b. City, Town, or Location of Death

CLINTON

3. Time of Deeth FEBRUARY 28, 2000 9:55PM

NEW COUNTY, VA

10d. Inside City Limits 1X Yes 2 No

Funeral

579-26-4825 Usual Residence of Decedent

1. Decedent's Neme (First, Middle, Last)

7. Age (In yrs. last birthday) 100 M 20 F 83

If Under 24 Hrs. If Under 1 Yeer Days Hours

PRINCE GEORGE'S 8. Dete of Birth (Month, Day, Year) NOV. 9, 1916 9. Birthplace (State or Foreign

4c. County of Death

Director

288-4

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flams 23a

"natural", or

Hyglene.

. Pages 1 and 2 should be filled w firment of Health and Mental Hygier tant: If them 27 is marked other th jury or other traumatic event, the

Physician /Medical

Examiner

physician and the burief-transit

signed by the

page 2

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After

filled in by

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death.

ne Hospital or Attandi n 24 hours after death ne Funeral Director: A

To the Hosp within 24 ho To the Fune completely fi

Box 68760

P.O.

Records.

Division of Vital

Examiner

Physician/Medical

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Completed

Be

Certification: To

Medical

the Manyland

72 hours after

Baltimore, Maryland 21215-0020

10b. County MARYLAND

PRINCE GEORGE'S

10c. City, Town or Location SUITLAND

10g. Citizen of What Country?

2. Dete of Deeth

10e. Street and Number

2432 GREEN VALLEY DRIVE

20746 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 14. Race - American Indien,

1 Never Married 2 Married 3 Widowed 4 ☐ Divorced

12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

1 Yes 2 No Specify:

10f. Zip Code

Bleck, White, etc. BLACK Specify

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12)

College (1-4or 5+)

16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

GOVT.

8th

PLASTERER

18. Mother's Neme (First, Middle, Maiden Sumame)

17 Father's Neme (First Middle Last)

CORBIN HENRY MACON

JULIA CHRISTIAN

19a. Informent's Neme/Relationship (Type, Print) ALONZO LEO MACON/ SON

19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9003 SUSAN LANE CLINTON, MARYLAND 20735

20a. Method of Disposition

1 DBurial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place) FT. LINCOLN CEMETERY 20c. Location - City or Town, Stete

3/6/00

BRENTWOOD, MD

21. Signature/of Funerel Service Ligana

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.

4308 SUITLAND RD.

22. Name and Address of Facility MARSHALL S FUNERAL HOME OF MD 20746 SUITLAND, MD

Immediate Cause (Finel

Approximate Interval Between Onset and Deeth ~

disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last

Due to (or es a consequence of): Due to (or as a consequence of)

0

Nosus

Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24e. Was an autopsy performed?

24b. Were eutopsy findings available prior to completion of cause of death?

1□ Yes 2₽No 26. Place of Deeth (Check only one)

1 ☐ Yes 2 ☐ No

25. Was case referred to medical 1 Yes 2 No

27. Manner of Death

1 Natural

2 ☐ Accident 3 Suicide

4 Homicide

5 Pending investigation 6 Could not be

MEE

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year)

28e. Place of Injury - At home, larm, street, fectory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

AVE, Tugh Hills MD 20748

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RED 31. Date liled (Month, Day, Year) MAR 0 2 2000

4467 old Branch 2. Registrar's Signature

Registrar

1805 5.5 3000 Johnson

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** EBRURE 128 2000 John Edward McAdams /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** USSALVE TON Town Washington County Hospital If Under 24 Hrs. If Under 1 Year Birthplace (Stata or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 □ F Yrs 478-18-7870 82 Director Dec. 30, Iowa Usuei Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Washington 238-4 Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? hems 23a or 21713 8507 Mapleville Road U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Merried 1 X Yes 2 No If Yes, Give 8 21215-0020 1 Yes 2 No Specify: Specify: White by 3 Nidowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamantary/Secondery (0-12) College (1-4or 5+) 5+ Federal Government Accountant aryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be William Henry McAdams Elizabeth Anna Mack 19b. Meiling Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) tant: If item 27 is Linda K. Tweit - Daughter 19331 Garretts Mill Road, Knoxville, MD 21758 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Othar (Specify) 03/04/00 Suitland, Maryland Cedar Hill Cemetery 21. Signeture of Funeral Service Licensee 22. Name and Addrass of Facility Gasch's Funeral Home, P.A. 23a. Part1. Enter the diseesa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or raspiratory arrest,

Approximate shock, or heert failure. List only one ceuse on aech lina. Approximata Interval Between Onset and Death Physician /Medical Immediete Ceuse (Finel (0 dos) freumans diseesa or condition resulting in death) **Examiner** Due to (or es a consequence of): Examiner Hamit 1000 Consentin failer Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last and Due to (or es e consequence of): Anterio relentie Cardinarale Physician/Medical å Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unitinown Myxentine signed t Records. Aq 24b. Wera autopsy lindings available prior to completion of cause of death? Hopsthyroding Suiz Academi Completed 24a. Wes an autopsy performed? Garguen 1 TYBR 2 HNO 1 Tyes 2 No Division of Vital Attending Physician: 25. Was casa referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 SNatural 5 Pending 1 Yes 2 No death. investigation 2 Accident n 24 hours after death be Funeral Director: A pletely filled in by the f 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, lectory, office building, atc. (Specify) 4 Homicide ò 1 Cartifying Phyaician: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) end mannar as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29e. Certifier (Check only one) within 2.
To the F 29c. License number 29b. Signature and title of certifier 29d. Data signed (Month, Day, Year) FEB 28 2000 -(32ams A 18019 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 334 Datta Hagerstown, Md. 21740 9 31. Dete liled (Month, Day, Year) 32 Registrer's Signeture MAR 0 1 2000 Registrar

MAR 1 2000 Sure de spaces

Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 08764

					001	unca	ie ui	Death			Reg. No.		
	1. Decedent's N	Name (First, Middle,	Last)	011111111111111111111111111111111111111						2. Date of De Month	eath Day	Year	3. Tima of Desth
sician edical	Sarah		February 29, 2000 5:20										
miner	4e Facility Nan	ne (If not institution,	give street and nu	ımber)			-	4b. City, Tov	wn, or Loc	ation of Deat		County of Dee	
	Prince George's Hospital Cheverly									Prince Geor			eorge's
eral	5. Social Securi		. Sex		. last birthday)		r 1 Year		24 Hrs.	8. Dete of Bir	rth	9. Bir	thplece (State or Fore
tor	577-24-	-7248	1□ M 2⊠ F	76	6 Yrs. Months Days		Days	s Hours Min.		8. Dete of Bio (Month, De March	18, 19	23 Vii	cginia
	Usual Residence	a of Decedent					l		-		,		0
	10a. State 10b. County 10c. City, Town or Location											10d. Insida City Lim	
ō	Manular	nd Prince	Coorgol	Нуга	ttsvill	0							1 ☐ Yes 2 🔯
Director	10e. Street end		George :	ilya	CCSVIII		p Code				10a Citiz	ten of What Co	ountry?
ā	1000 50						781				U.S.		Junity
<u>e</u>	4902 36	oth Avenue											
Funeral	11. Maritel Stet	us	12. Was Dec	edent Ever in lorces?	J,S. 13.	Nas Dece f Yes, spe	dent of I	Hispanic Original, Mexican	gin? (Spe , Puerto F	city Yes or No Rican, etc.)	0- 1	 Race - Ame Black, White 	
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by	3 Widowe	ed 4 Divorced	Year or I				- 22 110	op-ony.				Specify. WI	nite
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pie	-	Secondary (0-12)		1-4or 5+)	life.	DO NOT	ise retire	during most	OF WORKE	9			
0	11	1		,	House	wife					Own	Home	
Be	17. Father's Ne	me (First, Middle, La	ist)					18. Mothe	r's Name	(First, Middle	, Maiden S	Sumame)	
ToB	Estes V	Vernon Fle	mino					Sue 1	Mull:	ins			
-		's Name/Relationship			19b. Mailir	ng Addres	s (Street				er, City or	Town, Stete,	Zip Code)
To Be Completed by Funeral Director		encarini -		4								ryland	
	20a. Method of		- nusballe						Tyacı	Dete		cation - City or	
0000		2 Cremetion 3	☐Removal from	State 200.	Placa of Dispo cemetery, cres	natory or	other pla	100)					
		on 5 Other (Spe			te of I	Heave	en Ce	emeter	y 03	/02/00	Silv	er Spr	ing, MD
9000	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Gasch's Funeral Home, P.A.												
8	Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville												MD 20791
	22a Porti En	tor the disease or or	emplications that	aused the de								viiie,	Approximate
-	23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
an	Immediate Cause (Final												Onset and Death
eal ner	diseese or con-	dition	. Dehv	dration	/ Shoo	ck							
177	resulting In dea	ath)			or as a consec):						
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Examiner	Sequentially lis	st conditions	Ь.		or as a consec	-							
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clan/Medical Examir	I that initiated ev	ents	c. Meta	static	or as e conseq								
8	resulting in dea	ith) Last											
3			d. Aden	ocarcir	oma of	Lung	5						
<u>6</u>													l 1
/ Physician	Part II. Other el-	gnificant conditions	contributing to	leath but not re	sulting in the u	nderlying	cause gi	iven in Part I.		23b. Did	tobacco	use contribut	e to the cause of dea
Ph										15	Yss 2	□ No 3□ F	robably 4 Unkn
by									_				
8											s an autop	sy 24b.	Were autopsy finding available prior to
									_				completion of cause of death?
oleted										10	Yes 2X	TNo	1 ☐ Yes 2 ☐ No
omplet										1		5140	10 165 20 110
Comp							10	26. Place	of Death	(Check only	one)		
Be	25. Was case re examiner?	eferred to medical	Hoepitat:				OA O	4 □ Nu	rsing Hon	ne 5 Res	idenca 6	Other (Spe	ecify)
To Be	examiner?	2 <mark>∑</mark> No	-		ER/Outpatier				1				
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month 02 23 Day **Physician** LUCINDA MARTIN 2000 10:30AM /Medical 4b. City. Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner PRINCE GEORGE'S MAGNOLIA GARDENS NURSING HOME LANHAM If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 M 2 X F 578-26-2650 93 Yrs **Director** July 10, 1906 Virginia Usual Residence of Decadent with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince George's 1X Yes 2 No Lanham Maryland Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Examiner must be r U.S.A. 9417 Sheridan Street 20706 Funeral 72 hours efter death 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0020 *natural', or 1 Yes 2 No Specify: Black þ 3 Widowed 4 Divorced r than "nature the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Depertment of Health and Mental Hygiene. Important: If tem 27 is marked other than "nat any injury or other treumatic event, the Medica 000. Elementery/Secondary (0-12) College (1-4or 5+) 5th House Keeper Private 17. Fether's Name (First, Middle, Last) 18. Mother'a Name (First, Middle, Maiden Sumame) Be Benny Amos Lucy Hill 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucinda Washington/Granddaughter 9417 Sheridan Street, Lanham, Maryland 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 03/04 1 ☐ Burlal 2 X Cremation 3 ☐ Removal from State Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2000 Beltsville, Maryland 21. Signature of Funeral Service Licanse 22 Name and Address of Facility
J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tellure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or as a consequence ot): Examiner ettending physician and for usa as the burial-transit the death certificate be axecuted Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence ot): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or es e consequence of): signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 dunknown 1 Yee 2 No by 24b. Were autopsy findings available prior to Completed 24e. Was an autopsy performed? completion of cause of death? certificate has b irector, pege 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Was case reterred to medical exeminer? Be 26. Place of Death (Check only one) To Other: 4 United Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 1 Yes this 28a. Date of injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After Hospital or Attending 5 Pending investigation 2 No death. 1 Yes 2 Accident the 6 Could not be 3 ☐ Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, State) in by 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) aftar 4 Homicide F 24 hours o the Fun. edical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as atlated. (Check only one) The basis of exemination and/or Investigation, In my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Dete signed (Month, Day, Year) 30. Neme and add death (Item 23a) (Type, Ppl 201 31. Dete filed (Month, Day, Year) Registrer's Signature MAR 0 3 2000 Registrar

200 62 2000 Same D. Sant

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 3. Time of Death 1. Decedant's Nama (First, Middla, Last) Month **Physician** 2000 Eloise J. McNeil1 March 2, 6:30AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) Examiner Mariners Health Care Center Prince Georges Clinton If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2⊠F Director June 10,1922 260-01-1348 Georgia Usual Rasidance of Decedan r 28a-f show 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 XYas 2 No Directo Prince Georges Clinton 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? pernit. Pages 1 end 2 should be filed within 72 hours after deeth with til Departmant of Heelth end Mental Hygiena. Insportant: If Itam 27 is marked other than "naturel", or itams 23a or 2 any injury or other traumatic event, the Medical Examinat must be nature. 9211 Stuart Lane 20735 United States Funeral 14. Race - Amarican Indian, 12. Was Decedant Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Black, White, etc. 1 ☐ Yas 2 ☑ No If Yas, Giva Year or Datas: 1 □ Nevar Married 2 □ Married Baltimore, Maryland 21215-0020 Specify: Black 1 Yes 21 No Specify: p 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Elementery/Secondery (0-12) College (1-4or 5+) Nurse D.C. Village 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meiden Sumema) Be 2 Zenious Johnson Ella Clark Johnson 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Coda) ter 5001 Rayburn Place Camp Springs, Maryland

20b. Place of Disposition (Nama of comatary, cramatory or other place) Carol E. McDonald/daughter 20748 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata 3/11/00 Laurel, MD. 4 □ Donetion 5 □ Othar (Specify) MD. National Cem. 22. Nama and Address of Facility Hodges & Edwards F.H. of Funaral Sarvice Licansee 13910 Silver Hill RD. Su hock, or haard failura. List only one cause on each line. 3910 Silver Hill RD. Suitland, MD. 20746 Approximete Interval Between Onsat and Death **Physician** /Medical Immediate Cause (Finel Week disaasa or condition Examiner Due to (or as a consequence of) Examiner certificate be executed physician end the burief-trans Sequantially list conditions, if any, leading to immadiate causa. Entar Undarlying Causa (Disaase or Injury that Initiated avants resulting in death) Last Due to (or as a consagi Box 68760. physician edicai Dua to (or as a consequence of): 98 Physician/M 980 signed by the e 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Wera autopsy findings available prior to complation of causa of death? 24a. Wes en eutopsy performed? Completed page 2 has 1 Yas 2 NO 1 ☐ Yas 2 ☐ No certificate or Attending Physician: funeral director, 25. Was case rafarred to medical exeminer? Be 26. Place of Deeth (Check only ona) Othar: 4 Nursing Homa 5 Residanca 6 Othar (Specify) 1 Yas 2 No Certification: To 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 27. Manne of Death 28b. Tima of 28c. Injury at Work? 1 Netural 5 Panding 1 🗌 Yas 2 🗆 No death. invastigation 2 Accidant s after death 6 Could not be datermined 3 ☐ Suicida 281. Location (Street and Number or Rural Route Number, City or Town, Steta) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Spacify) 4 Homicida Hospital within 24 hours Medical 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, and due to the ceuse(s) and manner as stated completaly 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signatura and Ita of certifiar, 29d. Data signed (Month, Day, Year) 30. Nama and addrass of person who complated caysa of death (Item 23a) (Type, Pent)

C-101

Ave. CAMP Springs. Md

Registrar

Durwa

MAR 0 3 2000

32. Ragistrar's Signatura

31. Date filed (Month, Day, Year)

MAR 0 3 2898 Burn D. Jones

Phys /Me

		State of Ma			rtment o			Mental Hy	giene Reg. No	U	0	08767		
Physician /Medical	1. Decedent's Name (First, Middla, La Sylvia		elson					2. Data of De Month FEBRU	eath De		ear 2000	3. Time of Death		
Examiner												of Death nce George		
Funeral Director		Sex 1□M 2 F 7. Age	(In yrs. last birt	rhday)_ Yrs.	If Under 1 Y Months Da	ear	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Di Oct.	rth ay, Year I 6,	1908	O. Birthple Count New	York		
the Maryland 28a-f show notified at	Usual Rasidence of Decedent 10a. State 10b. County Maryland Prince	George	ation ollto	n					10	d. Inside City Limits				
ther death with the Ma r ferms 23a or 28a-1a ther must be notified Funeral Director	10e. Street and Number 8413 Cathedral	Ave.			10f. Zip Cod 2 0 7					tizen of Wh				
0 0 0	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant E Armed Forces? 1 Yas 2 N If Yes, Give Yaar or Dates:			as Decedent Yes, specify (panic Origin? (Sp , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	0-	14. Raca - Black, Specify:	White, e			
permit. Peges 1 and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: If from 27 is marked other then "natural", any injury or other traumatic event, the Medical Exi- angle. To Be Completed by	15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12) 1.2											ustry		
1 and 2 should be filed with Health and Mental Hygiene, em 27 la marked other ther ther traumatic event, tre. To Be Comp	17. Father's Name (First, Middle, Last Adolf Michel 19a. Informant's Name/Relationship	son	10h	Matting	Addrace (St		I8. Mother's Nam Unkno	wn				Codel		
les 1 and 2 s of Heaith an of Hem 27 is 1 of other trau	Lorraine Ecker	t/Dau.in	1aw 8	413 Disposi	Cath	edi	ral Ave		Can		ton	, MD 2078		
permit. Peges Department of Important: If it Iny injury or o									delph	phi, MD.				
permit. Departi	21. Signatura of Fund al Service Lice	March	08	2		rro	oll St.	NW. Y	Wasl			al Home. DC.20012		
Physician	23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications thet caused one cause on each line	the death. Do n	ot enter	the mode of	dying,	such as cardiac	or respiretory e	errest,			Approximate interval Between Onset and Death		
/Medical Examiner	Immediata Cause (Final disease or condition resulting in death)		ROVAS Due to (or as e o			01	SEASE				- (3 VEARS		
t be executed sician and burial-transit	Sequantially list conditions, if any, leading to Immediata cause. Enter Underlying Cause (Disease or injury that initiated events	. ARTERIU	0-4.5	BOT	1C C	AR	DIOVAS	RULAR	30	ISEA	E 6	5 YEARS		
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at the death 1 by the etter etached for u	Part II. Other eignificant conditions of	contributing to death but	t not resulting in	the unc	derlying causi	e given	in Part I.			. /		the cause of death?		

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

certificate has been signed by the ettending physician end lirector, page 2 should be detached for use as the burial-transit

Be Completed by

Medical Certification: To

To the Hospital or Attending Physician: The law requires that tha death certificata be executed Division of Vital Records, P.O. Box 68760,

SYVIA MICHELSON

Baltimore, Maryland 21215-0020

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Deeth (Check only one)

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No

20784

25.	Was case		to	medical	
	examiner?				
	1 ☐ Yes	2 No			
	. [] .00				
27.	Manger of	Death			

Naturel
2 Accident 5 Pending investigation 6 Could not be determined 3 Suicide

1 Inpatient 28a. Dete of injury (Month, Day Year) 28e. Plece of injury - At home, farm, street, fectory, office building, etc. (Specify)

2 ER/Outpatient 3 DOA 28b. Time of Injury

4 Nursing Home 5 Residenca 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

Other:

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

4 Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatu

29c. License number

29d. Data signed (Month, Day, Year)

0

State

Registrar

completely filled in by the funeral director,

this

After

within 24 hours after death. To the Funeral Director: A

WILLIAM ROSSON 31. Date filed (Month, Day, Year)

30. Nama and address of person who completed cause

MAR 0 3 2000

32. Pegistrar's Signature

death (Item 23a) (Type, Print)

1 Day & march 6005 6 5 895

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 08768

			Certifi	icate of L	Death	R	eg. No.	00100.		
Discovering to the second	1. Decedent's Neme (First, Middle, La	st)				2. Dete of Deat Month	h Day Ye	3. Time of Death		
Physician /Medical	JESSIE E.	MAYBERRY				March	1 20			
Examiner	4a Facility Neme (If not institution, given	e street and number)		41	b. City, Town, or L		4c. County of D	Death		
	Fallston Gener	al Mospital			allston	the contract of	Harfor	d		
Funeral Director	5. Social Security Number 6. S 216-48-4755 Usuel Residence of Decedent	7. Age (In yr. 84		Under 1 Year onths Days	Hours Min.	8. Dete of Birth (Month, Day, 7/10/1	Birth Day, Year) 9. Birthplece (State or Foreign Country) 11915 Maryland			
2 1	10a. Siele 10b. County	10c. C				10d. Inside City Limits				
with the Maryl or 28a-1 she be notified a	MD Harf	ord	Pyles		Med In		1 □ Yes			
ath with 1 23a or 1 authen	10e. Street and Number 5200 Rocks Ro		bear	0f. Zip Code 21132			t Country?			
0020 ours after death viril, or hems 234 Examiner must.	11. Merital Status 1 Never Married 2 Married 4 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes ₹₹No If Yes, Give Year or Detes:	1 ☐ Yes ★ No If Yes, Give 1 ☐ Yes 🔏 🖸			ecify Yes or No- Rican, etc.)		American Indian, Vhile, etc. te		
Maryland 21215-0020 A should be filed within 72 hours at th and Mental Hygiens. This marked other than "natural", or traumetic event, the Medical Exam To Be Completed by I	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		College (1-4or 5+) (Give kind of wo life. DO NOT u			ing	16b. Kind of Busine	ess/Industry		
Co ment	17. Father's Neme (First, Middle, Last		Homer	maker	18. Mother's Nem	. /First Middle N	Maidea Sumama)			
Be state	Walter Mc				Ada No		varuen sumame)			
Tyla d Men d d Men d Men			40h Maritime An	ddaean (Otean)	-		City on Your Cla	to 7in Codel		
Mag d 2 a 7 la a 7 la a 1 la a	19a. Informant's Neme/Reletionship (City or Town, Ster			
De Tage	John R. Mayber 20a. Method of Disposition		Place of Disposition	n (Name of	1		20c. Location - City			
altimore mit. Pages 1: partment of He portant: if her y injury or oth	XS Burial 2 ☐ Cremetion 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removel from State y) Ha	rford Me	em. Gd	ns 3/		Aberde			
Banking Samuel Bankin	21. Signeture of Pareral Service Licer	Marche	Lep Harl	me and Addres kins F	s of Fecility . H . Inc .	, 600	MAin st	7314 .,Delta,PA		
Physician /Medical Examiner	23a. Part I Enter the disease(or composition or heart failure. List only immediate Cause (Finel disease or condition resulting in deeth)	acid	Le My	XOCar				Approximate intervel Between Onset and Deeth		
Box 68760, seth certificate be associted offer use as the burlet-transit for use as the defect Examiner clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enler Underlying Cause (Diseese or injury that initieted events resulting in death) Last	c	(or es a consequenc							
O. Bo be death the etter thed for un	Part II. Other significant conditions of	ontributing to death but not re	esulting in the under	ying ceuse give	n in Part I.	23b. Did to	bacco use contrit	outs to the cause of death?		
P deta	chronic à	Corractiv	e lui	if c	dislus	2 2000	es 2□No 3[Probably 4 Unknown		
aw requires to the second and second as the	acute on d	bronic re	med i	usuff	illucy	24a. Wes a perform	ned?	4b. Were autopsy findings available prior to completion of cause of death?		
f Vital Re in yelden: The in director, pege for Com	25. Wes case referred to medical				26. Place of Deet		0			
of Vita Physician: this certific rel director,	examiner? 1 ☐ Yes 2⊠ No	Hospitel: 10 Inpatient 2	☐ ER/Outpatient 3	DOA Othe	uir .		ence 6 Other (Specify)		
ng Ph flar thi inerel	27. Manner of Death 10 Netural 5 Pending investigation	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work			ow injury occurred	<i>y</i>		
	3 Suicide 6 Could not b determined	28e. Plece of Injury - At building, etc. (Special	home, ferm, street, f cify)	fectory, office		28f. Location (St City or Town	reet and Number on, State)	or Rural Route Number,		
To the Hospital or within 24 hours after To the Funerel Dir completely filled in Medical Cert		ysician: To the best of my kr niner: On the basis of examir and menner steted.								
Me Me	29b. Signature and title of certifier		4	29c. License	number	2	9d. Date signed (N	fonth, Day, Year)		
/	> Hous I	en (Ful		D3-	7364	W	ard 1	, 2000		
0	30. Name and address of person who	completed cause of death (Ite	om 23a) Gypo, Print	, Ma	ryland					
State	31. Date filed (Month, Day, Year) MAR 3 - 200	32 Registrar's Sign	nature 6	book	10					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

				State o	r Marylan		partment of h partificate of			giene Reg. No.	JU	08/69		
Physic /Med	ical	1. Decedent's Name (I	4b. City, Town, or L	2. Dete of De Month Februar	Day y 26, 20	Year 000	3. Time of Death 5:17 A,M,							
Exami Funera Director		4a Facility Neme (If no Prince Geo: 5. Social Security Num 579-12-5212	rges Hos	spital (lest birthde Yrs.		Chever1	У	Princ	e Geo	orges ace (State or Foreign Ygton, DC		
pue M.		Usuel Residence of De 10a. State 10	ocedent Ob. County		10c. Cit	y, Town or	Location				10	d. Inside City Limits		
Meryl -f sho	tor	Maryland P	rince Ge	eorges	Mt.	Rain	ier					1 ☐ Yes 2 ☒ No		
h with the 23a or 28a	Funeral Director	10e. Street and Number 4510 31st		et			10f. Zip Code 20	712		U.S.A.		ry?		
laryland 21215-0020 2 should be filed within 72 hours after death with the Meryland and Mental Hygiena. Is marked other than "nature!", or flems 23a or 28e-f show aumetic event, the Medical Examiner must be notified at	by Funer	11. Marital Status 1 Never Married 3 Widowed 4		12. Was Decedent Ever In U, Armed Forces? NOTYPES 2 □ No If Yes, Give WW II Year or Dates.			Was Decedent of H If Yes, specify Cub	dispanto Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Blac	e - America k, White, e white	tc.		
21215-0020 d within 72 hours af piena. r than "naturel; or the beat of the piene of	led within 72 hours a tygiena. Ngiena. ner than "natural; on the Medical Evan Completed by	(Specify (Specify Elementary/Seconde	Decedent's Ed only highest green ery (0-12)	ucetion de completed) Coilege (1	I-4or 5+)	(Gir	edent's Usuel Occup re kind of work done DO NOT use retire er Plumbe:	during most of work d)	ing	16b. Kind of Bu		ustry		
Hygi other	Be Co	17. Father's Name (First, Middle, Last) 18. Mother's Name								Meiden Sumem	10)			
Maryland d2 should be file th and Mental Hy 7 Is marked othe traumatic event,	Menta Merican Marked Marked	John	Albert	Nalls				Elizab	eth E.	Bell				
		19a. Informant's Name				19b. Ma	iling Address (Street	end Number or Rur	al Route Numb	er, City or Town,	Stete, Zip (Code)		
P - N -		Preston A.	· · · · · · · · · · · · · · · · · · ·	Son	20h F	4512	31st St	. Mt. Rai	nier, M		City or Tou	- Chain		
Baltimore, beymit. Pages 1 er gepartment of Hea important: if item; any injury or othe	permit. Pages 1 Reportment of H Important: If its any injury or oft	20a. Method of Dispos **To Burial 2 0 4 0 Donation 5	remation 3 Other (Specify) [emetery, ca Linc	oln Cemeto	ery March	2,2000		ood, M	ſD		
Bay and		21 Signature of Funer	al Service Licen	Lee	toel		22. Name and Addres 401 Blades							
Physician /Medical		23a. Part1. Enter the shock, or hear fe	eilure. List only	one aluse on e	ach line.						1	Approximate Interval Between Onset and Death		
Examiner		resulting in deeth)		a. / 4	Due to (c	r as a cons	equence of):	3.			1			
bed its	nine	Immediate Cause (Final disease or condition resulting in deeth) a. A water A to e crown Indeeth Indee									Lear			
8760, sete be axecuted hysician and the bunel-transit	dical Examiner	Sequentially list conditions, if any, leeding to immediate ceuse. Enter Undertying Cause (Disease or Injury that inflated events												
. BOX 68760, death certificate be asscuted e attending physician and d for use as the bunal-transit		resulting in death) Las	l	d	Due to (o	r as a cons	equence of):							
Beath death dfor u	Iclar	Part II. Other elections conditions contributing to dooth but not resulting to the underlying course sizes in Part II.								23b. Did tobacco usa contributa to the cause of death				
D.O. hat the sed by the detache	by Physician/Me	Part fl. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I.										ably 4 Unknown		
cord requir	Completed t									an autopsy med?	ave con	re autopsy findings liable prior to apletion of ceuse eath?		
The lev ate has pege 2	mo								10	Yes 2 No	10	Yes 2 No		
f Vital I ysician: The is certificate director, peg	Be	25. Wes cese referred examiner?						26. Plece of Deal	h (Check only	one)				
Physic this co	2	1□ Yes 2□ Mo			npatient 2		ent 3LI DOA			dence 6 Oth)		
On O ding Ph h. After th funeral	tlon		Pending investigation		th, Dey Year)	28b. Time Injury	Wo	rk? Yes 2□No	280. Describe	how Injury occur	190			
DIVISION Of VITA or Attanding Physician: eftar death. Director: After this certific in by the funeral director,	Certification:	2 Accident 3 Sulcide 4 Homicide	Could not be determined	28e. Place	of Injury - At he ng, etc. (Specif		street, factory, office		28f. Location (City or To	Street and Numb wn, Stete)	er or Rural	Route Number,		
The Hospital or A Fin 24 hours efter the Funeral Direct mpletary filled in by	edical C			Inar: On the ba			ath occurred at the ti investigation, in my							
To the	Me	29b. Signature and title	of certifier	11	/	A 11	29c. Licens	se number		29d. Dete signe	d (Month, D	Dey, Year)		
(1-))) ul	1/1	Yas	-/	713	27	W 0 1 4		2/2	(1)			
(15)		30. Neme end eddress		completed caus		23e) (Typ	e, Print)	tive pla	ice, # U	02 , Lc	nhon	mo -0706		
St Regist	ate rar	FEB 2 9 2		32. R	egistrar's Signa		ale							

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State of Maryland / Department of Health and Mental Hygiene

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-				Cer	tificate of	Death	7		Reg. No.			
-	1. Decedent's Neme (First, Middle,	Last)					2	2. Dete of Dea	ith Day	Year	3. Time of Deeth	
Physician /Medical		, JR.					FEB.	25, 200		9:20 p.m		
//wedical	An English Marra Mant institution	give street and number	er)			4b. City, To	own, or Loca	ation of Death				
	13033 CLARIO	FT. V	WASHIN	GTON	PRINC	E GEO	ORGE'S					
Funeral	5. Sociel Security Number	6. Sex 7.	Age (In yrs. last bi	irthday)	If Under 1 Yea	r If Under		B. Date of Birt (Month, Day	h Vand	9. Birthp	lace (State or Foreign	
Director	578 56 7991	tv∏M 2□F	55	Yrs.	Months Dey	s Hours						
9	Usuel Residence of Decedent	ovember21,1944 Washington DO										
of Man	10a. Stete 10b. County		10d. inside City Lin									
Mar Mar	Maryland Prince	George's	Fort V	Vash:	ington			1√2 Yes 2□N				
or 28e-1s be notified	10e. Street and Number	W. at the			10f. Zip Code			10g. Citizen of Whet Country?				
		ad			207	744		USA				
har death in the task siner must	11. Meritel Stetus	12. Wes Deceder		in U.S. 13. Wes Decedent of Hispanic Origin? (Sp if Yes, specify Cuban, Mexicen, Puerto				ify Yes or No-	14. Rao		an Indien,	
or the maker	1 Never Married 2 Merrie	Armed Force d 1 ☐ Yes 25						ican, etc.)	Bled	k, White,		
20 1	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Deter	I Yes 2 □ N	o Specify	<i>'</i> :		Specify	: B1	ack			
Of Share	15. Decedent's		166	16e. Decedent's Usual Occupation (Give kind of work done during most of work					16b. Kind of Bu	siness/înc	dustry	
1 21215-0 ad within 72 ho ygiens. we than 'natur 4, the Medical.	(Specify only highest Elemantary/Secondary (0-12)		5.)	(Give I	kind of work don OO NOT use retii	e <i>during</i> mo: 'ed)	st of working	7				
Paris de la constante de la co	12th	Cottega (1-4o		Entrepreneur					Body S	Shop		
Ind Se files d other event,		ast)		18. Moth	er's Neme (First, Middle,	Meiden Sumem	_	-			
na de						Je	sse Ma	ahone				
THE PERSON IN	19a. Informent's Neme/Raletionshi		19	h. Meilin	g Addrass (Stre				r. City or Town.	State Zio	Code)	
Maryland 21215-0020 d ahould be flud within 72 hours at th and Mental Hygiene. This marked other than "natural; or traumatic event, the Medical Exam To Re Commissed by 8	Ethel Neal /wife				3 Claric							
da Tage	20a, Method of Disposition		20b. Plece	of Dispos	sition (Neme of	A Land	I	Dete	20c. Location -			
Baltimore, semil. Pages t.a. Department of Hsa myostant if Heni my Injury or other mos.	1 □ Burla1 2 □ Cremetion		10	etery, cremetory or other place)						anodver, Maryland		
H 4 8 8 8	4 Donation 5 Other (Spe	**	naimo	-			1				-	
Ball Department in moon	21. Signature of Funeral Service Li	ress of Fecil	MARS!	HALL'S	FUNERAL	HOM	E					
20288	4308 Suitland Road Suitland, MD 2074											
	23a. Part1. Enter the disease or c	omplications that caus	ed the deeth. Do	not ente	er the mode of d	ying, such as	s cardiec or	respiretory er	rest,		Approximata Intarvel Between	
Physician	23a. Pant. Enter the disease or complications that ceused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart failure. List only one ceuse on each line.											
/Medical	Immediate Cause (Final disease or condition		LUNG CAN	CER						6	months	
Examiner	resulting in death)	0	Due to (or as a							1	montina	
وَ السامانية			D00 (0 (0) 23 2	COMBOQ	denoe or).					1		
68760, ficate be assected physician and as the burist-transit edical Examiner	Commentative that are additions	b	Due to (or as a	consequ	nence of).							
axac n an ial-tr	if any, teeding to immediate	8. X 1	500 10 (0) 03 0	0011304	001100 017.							
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x 687 entificate ling phys e as the	resulting in death) Last	Due to (or as a consequence of):										
X # # # 2		d										
is, P.O. Bo es that the death or igned by the attend be detached for us by Physician								1				
O. the dy the check the dy	Pert II. Other significant condition	s contributing to death	but not resulting	in the un	identying ceuse (given in Peri	1.		tobacco use contribute to the cause of death?			
P detac								10	rss 2□No	3 Pro	bebly 4 Unknown	
Records, F is law requires that is has been signed tge 2 should be det implested by P								240 14/00	an autonou	24h W	ere autopsy findings	
Cords requires been sign should be								perfo	an eutopsy med?	ev	eitebta prior to	
The law require tate has been signate has been signate. Should										of	mpletion of cause deeth?	
The la								101	es 2 No	1[Yes 2□ No	
Vital Recent The certificate irector, pag	25. Was case referred to medical					26. Plec	e of Death	(Check only o	ne)			
Of Vita Physician: this carific ral director,	examiner? 1 Yes 2 No	Hospitel:	tient 2 ER/O	utpetien	1 3D DOA	other: 4 N	lursing Hom	e 5X Resid	lance 6 DOth	er (Specif	v)	
Physeral diseased	27. Manner of Death	28e. Dete of tr		Time of					ow injury occur			
Attending Ir death. Attending by the fune	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		Dey Year)	Injury		Yes 2	No					
Division or Attending after death. Director: After Jin by the fune	3 Suicide 6 Could no determin	and 286. Piece of	Injury - At homa, f	erm, stra	set, fectory, offic	0	28			er or Rura	al Route Number,	
Division c tal or Attanding P is after death. all Director: After to led in by the funera Certification:	4 Homicida determin	building,	etc. (Specify)				- 7	City or Tov	m, Stete)			
Division or other Hospital or Attending Philipin 24 hours after death. On the Funeral Director. After this completely filled in by the funeral Medical Certification:	29a. Cartifier 1X Certifying	Physician: To the bes	st of my knowledg	a death	occurred at the	tima data e	nd place, an	d dua to tha	ceuse(s) and me	nner as s	tated	
he Hospin 24 hours he Funer pletsky fill	(Check only 2 Medicai E	caminer: On the basis	of examination er	nd/or inv	estigation, in my	opinion, da	eth occurred	d at tha tima,	data and place,	and dua to	tha cause(s)	
To the He ithin 24 To the Fu	29b. Signature and title of certifier	· / N	3.0.00		29c. Lice	nse number			29d. Date signe	d (Month.	Dev. Year)	
2 200	1/ /	- (/_	7				MD01					
(m)	//	U	~				MD21	339	Februar	7 29,	2000	
(1)	30. Name and address of person w											
	Naiyer A. Rizvi,	MD 3800 I	Reservoi	r Ro	ad NW Wa	ashing	gton D	C 2000	7-2197			
State	31. Dete filed (Month, Dey, Year)		strer's Signeture									
Registrar	MAR 0 1 208	JU DOM	and B		fra de	1						

SAR P 2 2090 ARR P 2 2090

NOFES, Clarence

741

DHMH 16 Ray 6/95

State Registrar

29b. Signeture and title of certifier

31. Date filed (Marth, Day Year) 2000

30. Name and address of person who complated causa of death (Item 23a) (Type, Print)

Andew Novakowski MD



125 N, MAIN ST. BEZ AIR, MODIO14

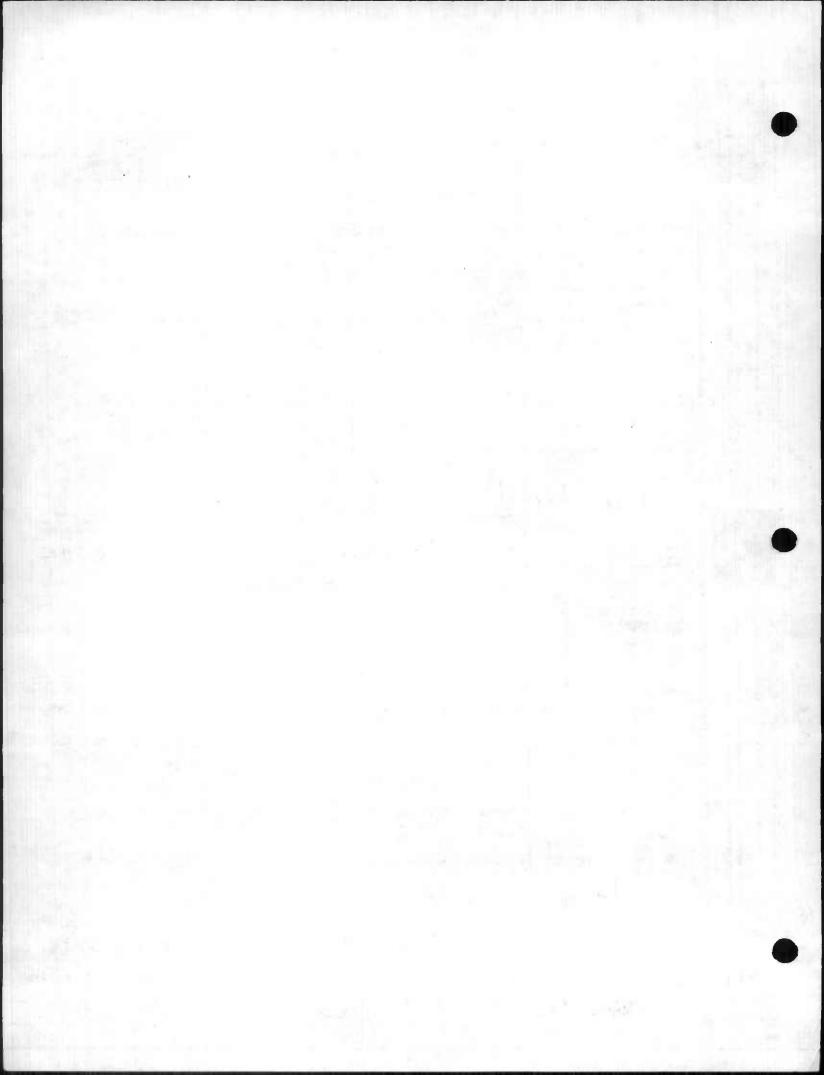
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29c. License number

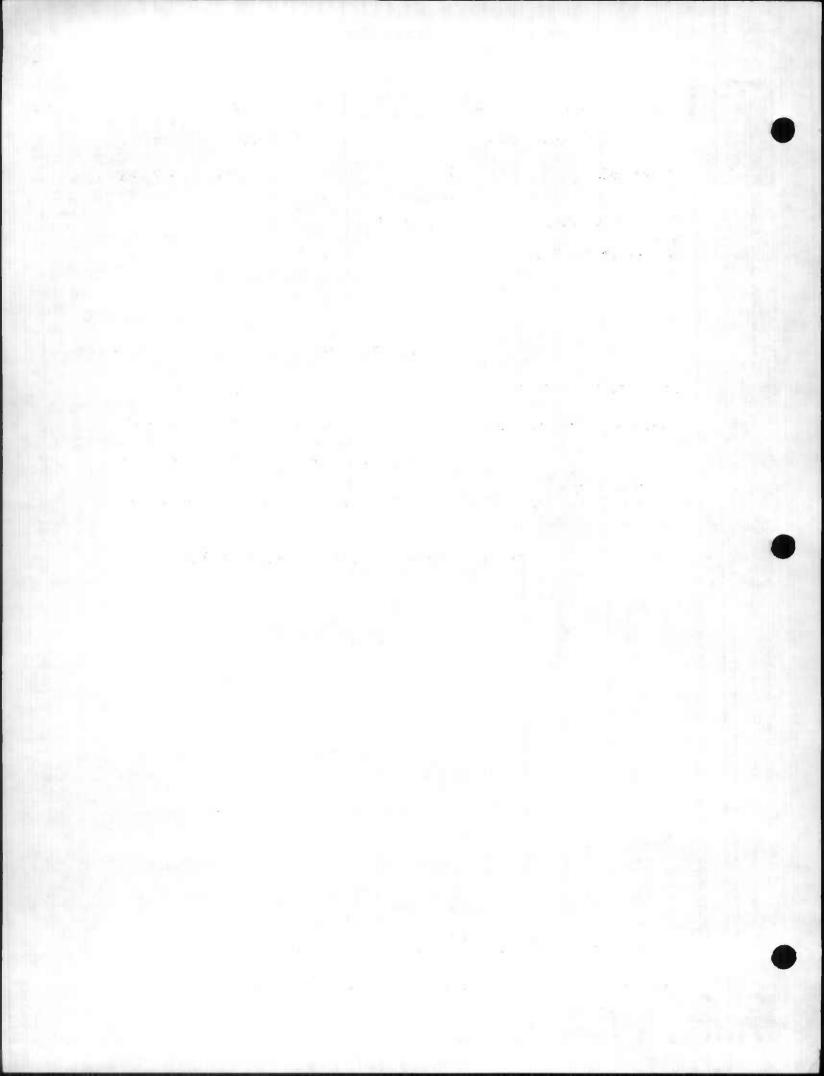
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29d. Date signed (Month, Day, Year)

14ARCH 2, 2000



ysician											Reg. No.			
ysıcıan	1. De	cedant'a Nama (First, Middle, La	ist)							Data of Das Month		Year	-	e of Death
Medical	F	RUTH AGATHA C	NDREJCA	ζ						ARCH	1,20	00		:30AM
aminer		acility Name (If not institution, given)			4	b. City, Town,		on of Death	4c. Co	unty of Dea	ith	
	-	1483 BRYANTOW						WALD				ARLE		
eral				ge (In yrs. las	st birthday) Yrs.	If Under Months	1 Year Days	If Under 24 Hours	Min.	Date of Birt (Month, Day	h v. Year)	9. Bi	rthplaca (State	te or Foreign
ctor			1□ M 2□ 5 XX	74	TIS.				Ap	ril 7	, 192	5 Mar	yland	
-	10a.	Residence of Decedent State 10b. County		10c. City.	Town or Loc	ation					-		10d, Insid	e City Limits
5	Ma	ryland Charles		1.	laldor	£							10	Yas 2 No
50	100	Street and Number	•	V	valuoi	10f. Zip	Code				10a Citizer	of What C		
	44	83 Bryantown Ro	nad			101. 210		0601				USA	John y .	
Examiner must be notified at by Funeral Director	11.14	larital Status	12. Was Decedan	t Ever in II S	13 W	Vas Deced			2 (Specific	Yes or No			erican India	n.
in in	11. 10	□ Nevar Married 2 Married	Armed Forcas	?	If	Yes, spec	ify Cuba	spanic Origin n, Mexican, P	uarto Rici	an, atc.)	Black, White, etc.			
by	. 3	Widowed 4 □ Divorced	If Yes, Give Yaar or Dates:		1	☐ Yes 2	X No	Specify:			Sp	ecity:	White	
- P		15. Decedent's E			16a. Deced	ent's Usua	1 Occupa	ation			16b. Kind of Business/Industry			
completed	-	(Specify only highast gr	ada completed)		(Give I	kind of wor OO NOT us	rk done d se retired	ation fu <i>ri</i> ng m <i>ost of</i>)	f working				- 1-1-1	
e E	FIE	ementery/Secondary (0-12)	College (1-4or	5+)	0wner	/Opei	rato				St	Store/Tavern		
Be C		ather's Name (First, Middle, Last)					18. Mother's Name (First, Middle,						
To B	Le	o Sisco Montgon	nery						et Agatha N					
T T	-	Informant's Name/Relationship			19b. Mailin	g Address	(Street 8	treet and Number or Rural Route Nur					Zip Coda)	
the the	An	drew J. Ondrejo	rak - Son		4511	Rryan	n t own	n Road	Wal	dorf	MD 2	0601		
etto		Method of Disposition	Jak - 3011	20b. Place of Disposition (Name of						Date			r Town, Stat	е
sician		Burial 2 Cremation 3 Donetion 5 Other (Special		9	Mary '				2 /	1-00	Dayan	town	Many	land
	-	lightfulla of Funeral Service Lice	-	St.				s of Facility	3-4	-00	bryan	cowii,	Mary	Idilu
		At the	1		Hu	ntt l	une	ral Ho						
		Part1. Enter tha disease, or com shock, or heart failure. List only			P	0 Box	× 15	6, Wal	dorf,	MD 2	0604-	0156	Approx	- 22
	Imme	ediate Causa (Final											Onsat a	and Death
ner	disea	ase or condition Iting In deeth)	a Breast	Can	cer w	rith	met	astas	is	to li	ver			
- T				Due to (or a	to (or as a consequenca of):									
iel-trensit Examiner			b								1			
el-tre	Sequ	ventially list conditions, y, leading to immediate e. Enter Underlying se (Disease or Injury		Due to (or a	as a consequ	uence of):							1	
		e. Enter Underlying se (Disease or Injury Initiated events	¢	0 4 4									+	
edic	result	ting in death) Last		Due to (or a	is a consequ	Due to (or as a consequence of):								
use as the		ting in death) Last	d											
		ring in death) Last	d											
			d							not Did				
_	Part II	Other significant conditions of	d	but not result	ing in the un	derlying c	euse give	en in Part I.						
ached for u			dcontributing to death	but not result	ing in the un	nderlying c	euse giv	en in Part I.			obacco ua			
be detached for u	-		dcontributing to death	but not result	ing in the un	derlying c	euse give	en in Part I.		10	Yss 2	No 3 1	Probably	4 🗆 Unknor
be detached for u	-		dcontributing to death	but not result	ing in the un	derlying c	euse give	en in Part I.		1 🗆 '		No 3 1	Probably . Were autopavallable promplation	4 Unknown
be detached for u	-		dcontributing to death	but not result	ing in the un	derlying c	euse give	en in Part I.		1 🗆 '	Yss 2 an autopsymed?	No 3 1	Probably Were autopavallable promplation of death?	4 Unknown
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octor, page 2 should be detached for u	25. W	Other significant conditions of the conditions		but not result	ing in the un	derlying c		28. Place of		1 24a. Was perlo	an autopsymed?	No 3 1 24b	Probably Were autory available promplation of death? 1 Yes	4 Unknown
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month Year Physician February 16, 2000 7:23 AM J. HERMAN OVERTON /Medical 4e Facility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner WASHINGTON ADVENTIST HOSPITAL Takoma Park MOntgomery If Under 1 Yeer | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 100M 20 F Director 76 Feb. 25, 1923 North Carolina 231-01-5108 Usual Residence of Decedent 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits show the Maryla Maryland Montgomery Takoma Park to Yes 2 No Director 28a-f 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? "natural", or hams 23s or 7440 Baltimore Avenue 20912 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Types 2 No 1944—
If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, Whita, etc. 72 hours after 1 Never Merried 2 Married 1 Yes 2 RNo Specify: Specify: Black 4 Yes, Give Yeer or Detes: 3 Widowed 4 Divorced 1945 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Demit. Pages 1 and 2 ahould be filled will Department of Health and Mental Hygiern important: if Nem 27 is marked other tra any fillury or other traumetic event, that alongs. 8th Building Engineer Woodward & Lothrop 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 88 Mack Smith Susie M. Overton 19a. Informant's Name/Reletionship (Type, Print) 19b. Maijing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Leona Overton - Wife Takoma park, MD 20912 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 Donetion 5 Other (Specify) 2-21-00 Wheaton, Maryland Parklawn Cemetery 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility
Marshall's Funeral Home, Inc. mashall 4217 9th Street N.W. Washington DC 20011 23a. Page. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Tyocanoiab Infanction /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner Examiner physicien end the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): edical Due to (or as e consequence of): for use es Physician/M 987 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 3 Probably - Unknown 1 Yes 2 No signed b P 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? Deen completion of cause of death? pege 2 1 Yes DENO 1 ☐ Yes 2 ☐ No cartificata To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cardifica completely filled in by the funeral director, it Be 25. Was casa referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient Nos 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Magner of Deeth 28b. Time of 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. 29e. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 245

State

Registrar

MANTIN H. BrOWN 31. Date filed (Month, Day, Year) FEB 2 8 2000

7600 CARROLL AVE 32. Registrar's Signeture

30. Neme and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

Records,

Division of Vital

TAKORS PANK, MO 20912

permit. Pages Department of Important: If it any Injury or o

Physician

/Medical

Examiner

Funeral

Director

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2 should be filed within 72 hours after and Mental Hygiane. Is marked other than "natural", or ite

Pages 1 and 2 s item 27 is other tra

The law requires that the death certificate be asscuted attending physician and for use as the bunal-transit cartificata has b this

Aftar this

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To the Hospital o within 24 hours aff To the Funeral DI completely filled in

Division of Vital Records, P.O. Box 68760,

Physician/Medical Examiner 2 Be 2 Certification:

Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Ceusa (Diseese or injury thet initieted avants rasulting in death) Last

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24b. Wera autopsy findings available prior to 24a. Was an autopsy performad? complation of cause of death? 1 Yas 2 No 1 Yes 2 No 26. Placa of Daeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how Injury occurred

1 Yas 2 No 27. Mannar of Deeth 1 Delatural 5 Pending invastigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicida

28a. Data of Injury (Month, Day Year) 28b. Tima of Injury 28e. Piaca of Injury - At homa, farm, street, factory, office building, atc. (Specify)

1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

(Check only one)

Cortifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, end due to the causa(s) and manner es stated.

2 Wadical Examiner: On the best of examinetion end/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated.

29c. Licansa number

29b. Signetura and title of certifier

29d. Data signed (Month, Day, Year)

30. Nema and addrass of person who complated causa of death (Itam 23a) (Type, Print)

R.G.BHOJRAJ.M.D. 704 GORMAN AVE#T-1, LAYREL, MD 2070

Registrar

edical

31. Data filad (Month, Day, Year) MAR 0 1 2000



DHMH 16 Rav 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** March 2, 2000 16:49 Gayle Patricia Palmer /Medical 4c. County of Death 4a Facility Name (II not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Hospital of Cecil County E1kton Cecil 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1□M 20 F Months Days Hours 61 September 12,1938 Director 221-24-2605 Delaware Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits YE Yes 2 No Director 288-4 Maryland Cecil North East 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 United States flerrs 23s 7 Russell Street 21901 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: "natural", or Baltimore, Maryland 21215-0020 Specify: White p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Homemaker Home permit. Pages 1 and 2 should be life.
Department of Health and Mental Hy Important: If them 27 is marked other any injury or other traumatic event. 18 Mother's Name (First Middle Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Johnson Natalie Borden 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Russell Street, North East, Maryland 21901 Gerald B. Palmer/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, State March 2000North East, Maryland 1 Denial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) North East Methodist Cemetery 21. Signature Funeral Solvice Licensee 22. Name and Address of Facility Crouch Funeral Home
127 South Main Street, North East,
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
shock, or heart failure. 21901 Maryland Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Pneumonia Examiner Due to (or es a consequence of): Examine Pulemale difa Chronic Obstruction physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) Box 68760 Physician/Medicai Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.0. 2 3. Probably 4 Unknown 1 Yes 2 No signed t Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Thoatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending P after death. Director: After t d in by the funera After 5 Panding investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) within 2 To the complete 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3/3/2000 Dui chil Hom D04823 MD 30. Name and address of person who completed cause of death (flem 23a) (Type, Print)

TUI CHHH HSU 223 West n West main st, Elleton prd 21921. 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 0 3 2000 Registrar

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedeni's Nama (First, Middla, Last) 3. Time of Death **Physician** Mary Proctor 2000 10:15AM March /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) **Examiner** 7852 Wicker Lane If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) La Plata Charles Birthplaca (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1□ M 2XXX Yrs. 217-68-5900 45 September 29,1954 Director Maryland Usual Residence of Decedent with the Maryland r 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Tyas 2 □ No Directo Maryland Charles LaPlata 10e. Streei and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23s or the Medical Examiner must be a 7852 Wicker Lane 20646 USA Pagas 1 and 2 should be filed within 72 hours after death nant of Health and Mental Hygiana. If item 27 is marked other than "natural", or items 23. Funeral 14. Race - American Indian, 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Black, White, etc. 1 Yes 2 No If Yas, Give X Year or Dates: 1 ☐ Naver Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Domestic 7 is marked other treumatic event, 17. Faihar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Martin J. Proctor Mary L. Savoy 19a. informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Proctor- Husband 7852 Wicker Lane LaPlata, Maryland 20646 item 2: 20b. Piece of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 ☐ Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) permit. Pagas Department of Important: If it any Injury or o ST. Peters Cemetery 3/7/2000 Waldorf, Maryland 21. Signature of Funeral Servica Licensee 22. Nama and Address of Facility Adams Funeral Home P.A. Aquasco, Maryland 20608 M00191 23a. Part1. Enter the issease, or complications the caused the death. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or healt ailure. List only one ceuse of each line. Approximete intervei Between Onset and Death **Physician** /Medical immediate Cause (Final Cardiomyopathy disaesa or condition resulting In death) Examiner Due to (or as a consequenca of) Examiner physician and the burial-tran Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Diseasa or Injury that initiated events resulting In deeth) Lest Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due jo (or as a consequence of) 2 880 a edy ty the a d be detached t 23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 TYes 2 No 3 Probably 4 ⊠ Unknown by 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24e. Wes en autopsy performed? page 2 1□ Yes XXNo 1 T Yes 2 No certificate Be 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Other: 4 Nursing Home X Residence 6 Other (Specify) 1□ Yes XX No Certification: To 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 報 27. Manner of Death 1 E Natural 28a. Date of injury (Month, Day Year) 28d. Describa how injury occurred 28b. Tima of 28c. Injury at Work? Attending 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be 3 □ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Placa of injury - Al homa, farm, straal, factory, office building, etc. (Specify) 4 Homicide Direc ò 24 hours • Funeral edicai 29e. Certifier XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) and manner stated. To the To To the To the I 29c. Licansa number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of cartifier D28352 March 2, 2000 30. Name and address of person who completed cause of deeth (item 23a) (Type, Print) Krishan Mathur,

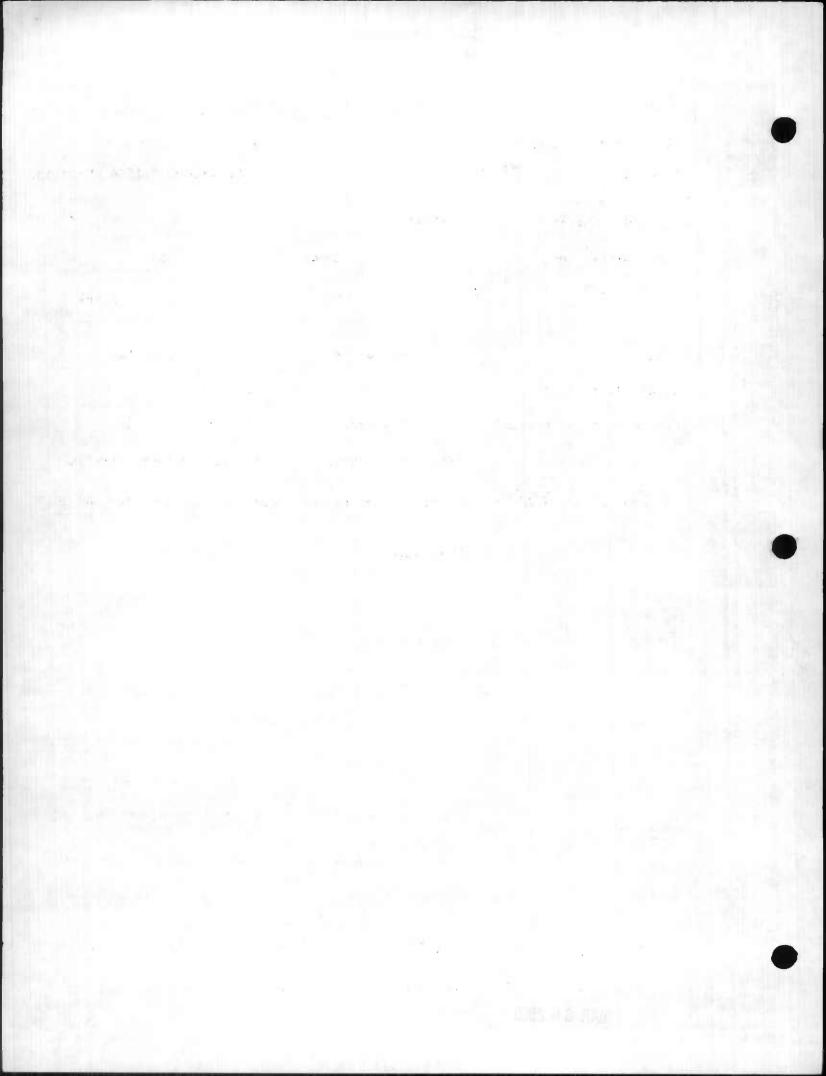
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31. Daia filed (Month, Day, Year)

MD., P.O. Box 1703, La Plata, MD 32. Regisyar's Signature

south

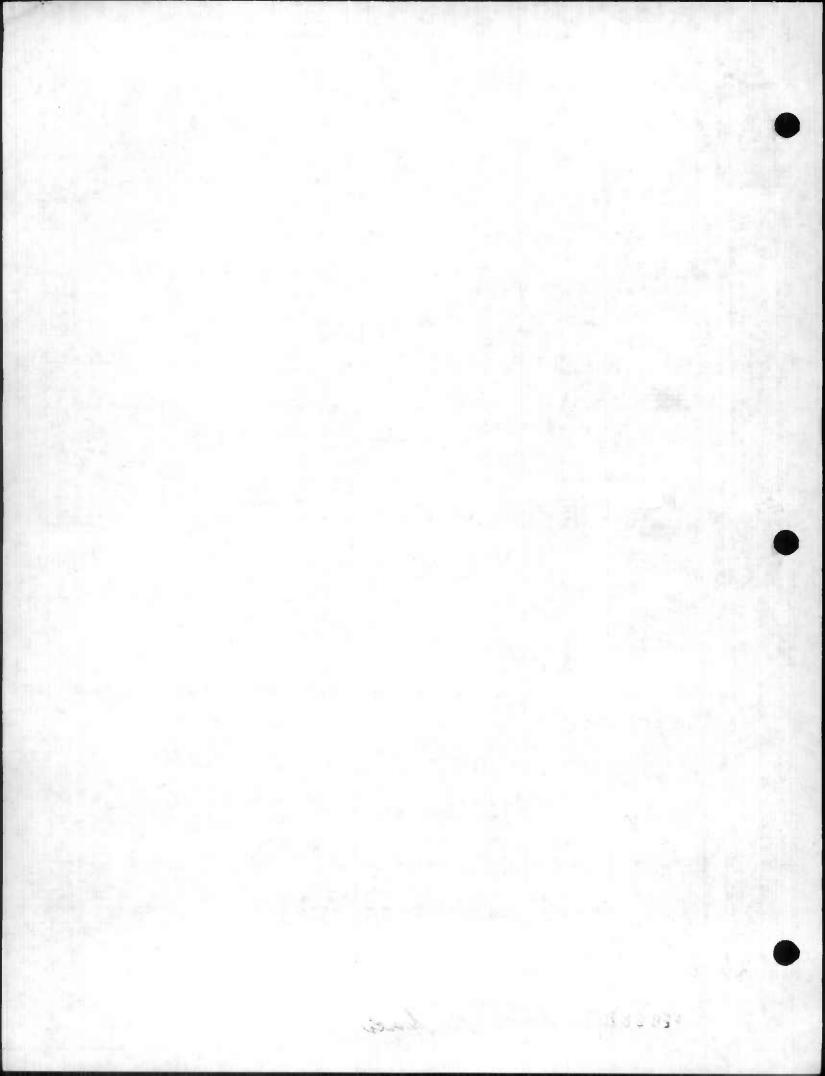


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 10 18777

	Certificate of	Death Reg. No.	00111
	Decedent's Nama (First, Middle, Last)	2. Data of Deeth Month Dev Yes	3. Time of Death
Physician /Medical	Jean Carolyn Paradis	February 24, 200	
Examiner	4a Fecility Name (If not institution, give street end number)	4b. City, Town, or Location of Death 4c. County of De	eath
4 4	Karen's Home	Laurel Prince G	George's
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) If Under 1 Year Months Days	H Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. 8	Birthplace (State or Foreign Country)
Director	578-05-4481 1 M 2 TF 81 Yrs. Months Days	July 15, 1918 Pe	nnsylvania
۶ ,	Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. fnside City Limits
anyla			1 X Yas 2 No
Ne M	Maryland Prince George's Hyattsville		
Vith to	10e. Street and Number 10f. Zip Code	10g. Citizen of What	Country?
ufer death with the Ma ritems 23a or 28a-fa iner must be notified Funeral Olrector	4908 55th Place 20781	U.S.A.	merican Indian.
er de	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forces? 1 Nevar Married 2 🕅 Married 1 Yas 2 🐧 No	Hispanic Origin? (Specify Yas or No- pan, Mexican, Puarto Rican, etc.)	
UZO Urs aff Br. or by F		Specify: Specify: \(\)	White
Maryland 21215-0020 d 2 should be filed within 72 hours after death with the Maryland th and Menial Hygiene. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	15. Decedent's Education 16a. Decedent's Usual Occur	pation 16b. Kind of Busine	ss/Industry
1 21215-0 led within 72 ho bygiene. her than "naturn ft, the Wolfer!	(Specify only highest greda completed) (Give kind of work done life. DO NOT use retire	during most of working	our modery
filed within Hygiene. there then end, the Me	Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary	Central I	Labor Council
tal Hyginal dother	17. Father's Neme (First, Middla, Last)	18. Mother's Neme (First, Middle, Maiden Surneme)	
should be and Mental or marked or umatic eve	Archibald Wertz	Flo McDowell	
Maryland 21215-0020 d 2 should be filed within 72 hours at the and Mental Hyglene. The marked other than "natural", or traumatic event, the Medical Exern To Be Completed by F		t end Number or Rural Route Number, City or Town, Stete	e, Zip Code)
e, Miland 2 Health a Health a Health a Health a	Lawrence J. Paradis - Husband 4908 55th Pla	ce, Hyattsville, Maryland	20781
Baltimore, North Pages 1 and Opportunit. Pages 1 and Opportunit. If then 27 any Injury or other words.	20e. Mathod of Disposition 20b. Place of Disposition (Nema of cemetery, cremetory or other place)	Data 20c. Location - City	or Town, State
Pages nent of mrt: If its	1 National Memorial		rch. VA
Copariting Copariting Information Informat	21. Signature of Funeral Service Licensee 22. Name and Addre	ess of Facility	
B T S S S S S S S S S S S S S S S S S S	Gasch's Fu	ineral Home, P.A. imore Avenue, Hyattsville,	MD 20781
5/4	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dyl shock, or heert failure. List only one cause on each line.		Approximeta
Physician	shock, or heert failure. List only one cause on each line.		Interval Between Onset and Deeth
/Medical	Immediate Cause (Final		70000
Examiner	Immediate Cause (Final disease or condition resulting in deeth) a. Alzheimer's Disease		gears
<u> </u>	Due to (or as a consequence of):		1
68/60, frificate be executed as the buriel-transit	Sequentially list conditions. Due to (or es a consequenca of):		1
Tier and M	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.		
The Cords, P.O. Box 68/60, The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the buriel-transit completed by Physician/Medical Examin	Cause (Disease or injury that initiated events Due to (or es a consequence of):		
og ph as the	resulting in death) Lest		
BOX sath cer attendir for use	d		
deat deat of to sel to	Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause gr	iven in Part I. 23b. Did tobacco use contrib	ute to the cause of death?
P.C.	11-1-1-1-1	1 ☐ Yss 2 ☐ No 3 ☐	Probably Tonknown
s tha	1 Apertension		
The law requires that the death certicate has been signed by the attending page 2 should be detached for use Completed by Physician/M		24a. Wes an autopsy performed?	tb. Were autopsy findings available prior to
s bee	•	pelicinisci	completion of cause of death?
ysician: The law his certificate has be I director, page 2 s		1 □ Yes 2 □ 16	1 ☐ Yes 2 ☐ No
Slan: T	25. Was case referred to medical	26. Piece of Death (Check only one)	
Attending Physician: r death. sctor: After this certific by the funeral director.	exeminer? 1 Yes 2 No	ther: 4 Nursing Home 5 Residence 6 Other (S	Specify)
Invision of vital or Attending Physician: 1 siter death. Director: After this certifical din by the funeral director. ertification: To Be C	27. Manner of Death 28a. Dete of Injury 28b. Time of 28c. Injury	The state of the s	
atio		Yes 2□No	
Atter Atter	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street end Number of City or Town, State)	r Rural Route Number,
DIVISION C ball or Attending P is after death. al Director: After t led in by the funers Certification:	building, etc. (Specify)	City of Youri, State)	
DIVISION OF The Hospital or Attending Phy Phin 24 hours after death. The Funeral Director: After this ampletely filled in by the funeral Medical Certification: 1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the ti	ime, date and piece, end due to the ceuse(s) and manne	r as stated.
he Hospit in 24 hour he Funeri pletely fill	(Check only one) 2 Medicaf Examiner: On the basis of examinetion and/or investigation, in my and manner steted.	opinion, death occurred et the time, date and place, and	gue to the cause(s)
M M	29b. Signeture and It of cartifier 29c. Lican	sa number 29d. Date signed (M	onth, Day, Year)
(23)	1 1/96 1/07	343() February	24, 2000
(20)	30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print)		
	John N. Margolis, M.D., 13952 Baltimore Avenu	ue, Laurel, Maryland 2070	7
State	31. Date filed (Month, Dey, Year) 32. Registrar's Signature		
Registrar	FFR 2.8 2000 Server & land		

DHMH 16 Rev 6/95



Physic	le.	1. Decedent's Nan		p .					2. Data of D		V.A	3. Tima of Death
/Medi			Lennie	Dorothy Tv	wine Pe	arce			Februa	ery 26,	Yaar 2000	6:35PM
Exami		4a. Facility Nama	(If not institution, g	riva straet and number	r)			4b. Clty, Town,	or Location of Das	th 4c. Coun	ty of Death	
Funeral Director		5. Social Sacurity I	Numbar 6.	ston Medica Sax 7. A 1□M 35€	al Cente Aga (In yrs. last 87		dar 1 Year ns Days	if Undar 24 H	shingtor lrs. 8. Data of B (Month, D Octob	n Prin er 2 19	9. Birth	eorge 1 S placa (State or Foreigntry)
with the Maryland a or 28a-f show the notified at	tor	10a. Stata VA	10b. County	N/A		own or Location sapeake						10d. Insida City Limits
r 28a-f si	rec	10e. Street and Nu	umbar			10f. 2	Zip Coda			10g. Citizan of	What Cou	
23a or	O is	1304 E	Edgewood	Avenue			2332	24			S.A.	
or items	by Funeral Director	11. Marital Status	τied 2∐ Married	12. Was Decedant Armed Forcas	k No		cedant of I pecify Cub		(Specify Yas or N arto Rican, atc.)		ace - Amarlack, Whita,	atc.
nat	Completed		15. Decedant's E	rede completed)	16	6a. Dacedent's Us (Give kind of v life. DO NOT	suai Occup work done Tuse retire	pation during most of w	vorking	16b. Kind of 8	Businass/In	dustry
giene.	mo:	Elementery/Sec	ondary (0-12)	Collage (1-4or N/A	5+)		emake			Own	Home	
al Hygie J other	Bec	17. Fathar's Nama	(First, Middle, Las	st)				18. Mothar's N	lama (First, Middle	e, Maiden Surna	me)	
marked	To		ed Prest						izabeth			Hobbs
27 ls			lame/Raletionship E. Paul	(Type, Print) (Daughter					Rural Route Numi Washing			
		20a. Method of Dis	•	□Ramovai from Stata	ann a	of Disposition (Notary, cremetory of	Veme of or other pla	ce)	Dete	20c. Location	- City or To	own, Stata
artmen ortant: injury		4 ☐ Donation	5 ☐ Othar (Speci	ify)		wood Mem	oria]	L Park	Mar 1, 2	000 Va	. Bea	ch, VA
Department of important: If any injury or once.		21. Signature of Fi	uneral Service Lice	90500	7				6633 018			erry RD
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hysician /Medical xaminer	(Immediate Cause										Intarval Between Onsat and Death
		disease or condition	on	- 111	eum	onia	_				1	
	ner	disease or condition resulting in death)	on	Ca	Dua to (or as	0.0000000000000000000000000000000000000	·6).	et Fa	ailure			
and Hransit	xaminer	resulting in death)	on /	b. Co	Dua to (or as M9 es	0.0000000000000000000000000000000000000	A).	et Fo	ailure			
siclan and	al Examiner	resulting in death)	on /	ь. Со	Dua to (or as M9 es) Due to (or as) CHEM	e consaquance of the laconsequance of la	Hean EAN	et for	ailure ASE			
nding physician and use as the bural-transa	Medical	Sequentially list co if any, laading to in causa. Enter Unde Causa (Disaase or that initieted avants rasulting in death)	onditions, nmadiata arlying r Injury	b. Co	Dua to (or as Due to (or as a Dua to (or a) Dua to (or as a Dua to (or a)	e consaquance of the laconsequance of a consequance of	Hean Hean EAN		ailure ASE			
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24 hours after death. Funeral Director: After this certificate has been signed by the attending tely filled in by the funeral director, page 2 should be detached for use a	edical Certification: To Be Completed by Physician/Medical	Sequentially list continues and sequentially list continues. Enter Under Causa. Enter Under Causa (Disaase or that initieted avantir rasulting in death) Part II. Other significant in the sequence of the se	onditions, madiate ariying injury stast Last floant conditions of the conditions of the conditions of the condition of the co	b. Color of Injury Annual Person of Injury Annual Pers	Dua to (or as Du	e consaquance of the aconsequance of the acons	Hean Hean Fly Gausa giv Causa giv	26. Pleca of D ar: 4 \(\text{Nursing} \) Yat \(\text{N} \) Yas 2 \(\text{No} \)	23b. Did 1	yas 2 No s an autopsy ormed? Yas 2 No one) idanca 8 Ooti how injury occu (Straet end Num wm, Stete)	ontribute to 3 Prol 24b. Www.co. of 15 har (Specifiered	ere eutopsy findings allable prior to mplation of causa death? Yas 2 No
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DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 10 02770

			Certi	ficate of			Reg. No.	, 0	00119
Physician	Decedent's Name (First, Middle, Last					2. Date of D Month	Dev	Year	3. Time of Death
/Medical	LORETTA TATE	PHILLIPS				Februa	ary 25 2	000	1:00 AM
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, o	or Location of Dea	th 4c. County	of Death	
file —	Fairfield Nursi	ng Center			Crowns	sville	Anne	Arund	el
Funeral Director	5. Social Security Number 6. Se 1577-70-2759	TM 0075		f Under 1 Year Aonths Days	If Under 24 H Hours Mi	in. (Month, D	rth ay, Year) 20,1952	9. Birthpl Count	lace (State or Foreign try) land
P	Usual Residence of Decedent								
how	10a. State 10b. County		City, Town or Locat	ion				10	Od. Inside City Limits
oto oto	Maryland Prince G	eorge's	Laurel						1 ☑ Yes 2 ☐ No
or 28	10e. Street and Number	TOTAL SEA		10f. Zip Code			10g. Citizen of	What Coun	try?
23a d	13601 Barnet Lane	, Apt #12		207	80		U.S	.A.	
Maryland 21215-0020 4.2 should be filed within 72 hours after deeth with the Maryland th end Mental Hygiens. 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Exercise must be notified. To Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 XNo if Yes, Give Year or Dates:		s Decedent of Hes, specify Cub. Yes 2 No		(Specify Yes or Nerto Rican, etc.)	Bla	ck, White, e	etc.
2 Pe 2 Pe	15. Decedent's Edu	cation	16a. Deceden	t's Usual Occup	pation	and in a	16b. Kind of Business/Inc		lustry
21215-0 ed within 72 ho or than "naturi it, the Medical Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO	NOT use retire	during most of w d)	vorking	0		
d withing giane.	12th		2ec	retary	Government				
ind 2 tel Hygie d other avent, it	17. Father's Name (First, Middle, Last)				18. Mother's Name (First, Middle, Maiden Surname)				
ylan buid be Mental arked o	Ernest Lee Was	shington			Lual	la Mars	h		
aryla should nd Mer merke umeric	19a, Informant's Name/Relationship (7)	ype, Print)	19b. Mailing /	Address (Street	and Number or	Rural Route Numi	ber, City or Town	, Stete, Zip	Code)
Md 2	Monquea L. Smith	uincy S	treet,	Ru <i>ral Route Number, City or Town, Stele, Zip Code)</i> #10, Bladensburg, MD 2071			20710		
other other	20a. Method of Disposition		h. Place of Dispositi	on (Name of		-	20c. Location		
Page Page ment of ury or	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		darmony Me	emorial	Park	02/29	-	er, M	aryland
Baitt Departm Importa eny Inju	21. Signature of Funeral Service Licens Non any A.	Per cantie				RAL HOME		2078	5
	23a. Part1. Enter the disease, or composhock, or heart tailure. List only o	lications that caused the d	eath. Do not enter t	he mode of dyir	ng, such as card	iac or respiratory	arrest,	- 1	Approximate Interval Between
Physician	and or notification. Else only o	TO CEUSO OIT GOOT IIT.							Onset and Death
/Medical	Immediate Cause (Final disease or condition	Multiple	Sclerosis					1	5 Years
Examiner	resulting in death)		o (or as e conseque					1	J lears
i i	5	000	o (or as a consequer	nos or).				- 1	
58760, fcate be assecuted physician and s the burlat-transit offical Examiner		b	. (0. 0. 0. 0.0000000000000000000000000					1	
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68760, ficate be an physician is the burla	Cause (Disease or injury that initiated events	C							
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hed de	Part II. Other significant conditions con	ntributing to death but not	resulting in the unde	orlying cause give	ven in Part I.	23b. Dic	tobacco use co	intribute to	the cause of death
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Of Vita Physician: this certific ral director,	examiner? 1 Yes 2 No	lospital:	2 ☐ ER/Outpatient	3 DOA OU	Mar.	Home 5□Res		ner (Specifi	v)
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on on the state of	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury		Yes 2 No				
DIVISION C but or Attanding P is after deeth. at Director: After t led in by the funer Certification:	3 Suicide 6 Could not be	28e. Place of Injury - A	t home farm street	factory office		28f. Location	(Street and Num	ber or Rura	l Route Number.
or A parties of A	4 Homicide determined	building, etc. (Sp.	ecify)	, tablery, omoc		City or To	wn, State)		
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To the Hospital within 24 hours To the Funeral complately filled Medical C		elclan: To the best of my ner: On the basis of exam							
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CAN CO	29b. Signature and title of codifier			29c. Licens			Februar		
	10, 1/M	MD		D 389	700		repruar,	у 23,	2000
(10)	30. Name and address of person who co	empleted cause of death (Item 23a) (Type, Pri	nt)					
()	DALJEET SINGH SID				106, Ode	enton, Ma	ryland	21113	
State	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature						
Registrar	FER 2 9 2000	beaute ,	9 las						

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State of Maryland / Department of Health and Mental Hygiene 00 08780

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ry1 P. Alexar	nder - Daughter	19b. Mailing Address ((Street and Number or Ru	ral Route Numbe	r. City or Town.	State, Zip Code)				
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Burial 2 Cremation 3	20h	Place of Disposition (Name		Date		City or Town, St	toto				
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		ryland Veter	ans Cem.	3/7/2000	Chel	tenham,	MD				
iture of Funeral Sarvice Joic	censee	22. Name and	Address of Facility								
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State of Maryland / Department of Health and Mental Hygiene [] 0878

					Cei	rtificat	e of	Death			Reg. No.		
	_	. Decedent's Name (First, Middla,	Last)		That Is					2. Data of De	ath		3. Time of Death
Physician /Modical	_	Henrietta	Pannell	L						Month Marcl	n l	2000	09:10A
/Medical Examiner	10.0	a Facility Nama (If not institution,	giva streat and n	umber)				4b. City, To	own, or L	ocation of Deatt	4c. Count	y of Death	
2.7.0		4620 Deepwood	Ct.					В	owie		Pri	nce G	eorge's
Funeral	5.	. Social Security Number 6	. Sex	7. Aga (In yrs.	. last birthday)	If Under		If Unda		8. Deta of Bir	th Vanal	9. Birthp	olaca (Stata or Fore
Director		465-32-0916	1□M 2√F	88	Yrs.	Months	Days	Hours	Min.	Dec. 1	th Year) 2, 1911	Te	xas
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vith the Ma tor 28a-fe be northed	1	0e. Sfreet and Number				10f. Zip	Code				10g. Citizan of	What Cour	ntry?
23a		4620 Deepwood	Court					2072	C		Uni	ted S	tates
filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or flems 23a or 28a-f show Mrt, the Medical Examiner must be notified as Completed by Funeral Director.	1	1. Maritef Stetus	12. Was De Armed I	cedent Evar in U	J,S. 13.	Vas Deced	dent of h	fispanto Or an. Mexica	igin? (Sp	ecify Yas or No Rican, etc.)	- 14. Ra	Race - American Indian, Bleck, Whife, atc.	
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2 sh and le m	1	9a. Informant's Name/Ralationship Evelyn Beck -								Wash.,		, <i>Stata, Zip</i> 20019	Code)
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/Medical		mmediata Causa (Final	(Cardiac Amythmia								t t	rewmnt.
Examiner	r	asulting in death)	a	Dua to f	or as e consec	uence di):							
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law requias been 2 should	-									perio		00	mpletion of cause death?
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Physical Phy		7. Manner of Death		a of Injury onth, Day Year)	28b. Time of	-	8c. Injui				how injury occu		,, , , , , , ,
tending leath. lor: After the fune cation		Netural 5 Pending invastigat		nm, Day Year)	Injury	М		Yas 2	No				
or Attending after death. Director: Atte d in by the fune ertification		3 Suicide 6 Could not	be 28a. Plac	ce of Injury - Af h	oma, ferm, str	eef, factory	, office			28f. Location (Street and Num	ber or Run	al Route Number,
bal or Attending P is after death. at Director: After t ed in by the funer Certification:		4 Homicide	buil	ding, atc. (Speci	<i>(ty)</i>					City or To	wn, Stata)		
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n 24 hound		(Check only 2 Medical Ex	aminer: On tha	basis of axamina	ation and/or inv	astigation,	in my c	pinion, de	th occur	red at the time,	deta and plece,	and due to	the cause(s)
within 2 To the comple		9b. Signatura and titla of certifier				290	. Licens	e number			29d. Data signe	ed (Month,	Day, Year)
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State Registrar	Ĭ	MAR 03 200	المرا ال	The state of the s	10.	gar.	La						
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				Ceri	tificate o	Dealli	F	Reg. No.			
5 1 -1-1-	1. Decedent's Name (First, Middl	e, Last)					2. Date of Dea Month	ith Dev	3. Time of Death		
Physician /Medicai	VERONICA CONS	STANCE PE	TRO				March	3, 20			
Examiner	4a Facility Name (If not institution	n, give street and numb	oer)				Location of Death	4c. County	of Death		
	1543 Bolling					Westmin		Carr			
Funeral Director	5. Social Security Number 202-16-1522 Usual Residence of Decedent	6. Sex 7. 1 □ M 2€MF	Age (In yrs.	last birthday) Yrs.	If Under 1 Ye. Months Day			, 1923	9. Birthplace (State or Foreign Country) Pennsylvan		
dand dand	10e. Stefe 10b. County		10c. Ci	ty, Town or Loc	ation				10d. Inside City Limits		
Mary Firsh tor	Maryland Ca:	rroll		Westm	inster	•			1 □ Yes 2√DNO		
r 28g	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Country?		
h wit	1543 Bolling	ger Rd.			21	157		USA			
n 72 hours after death with the Maryland **nature!*, or items 23s or 28s-f show edical Examiner must be notified a dical Examiner must be notified a leted by Funeral Director	11. Marital Stafus 1 Never Married 2 Man 3 XWidowed 4 Divorced	# Yes Give	es? ☑No		/es Decedent o Yes, specify C ☐ Yes 2 ☑ N	of Hispenic Origin? (Suban, Mexicen, Puer No Specify:	Specify Yes or No- to Rican, etc.)	14. Raci Blac Specify	e - American Indian, kk, White, etc. White		
	15. Deceden (Specify only higher	st grade completed)		16a. Decede (Give k life. D	ent's Usual Occ aind of work doi O NOT use ret	cupation ne during most of wo ired)	erking	16b. Kind of Bu	usiness/industry		
d within piana. Ir than Irs Me	Elementery/Secondary (0-12)	College (1-4	or 5+)	Home	maker			Own Home			
gas 1 and 2 should be filed to the that hand Mental Hygis or other traumatic event, a To Be Co	17. Father's Name (First, Middle,	Last)		**-		18. Mother's Na	er's Name (First, Middle, Maiden Surneme)				
should be nd Mental marked o matic ev	Ignatius Rem	ener				Mary	Martin	cek			
2 should and Men ie marke aumetic	19a. Informant's Name/Relations					eet end Number or R					
f Health if Health item 27 i	Diana Petro (Daughter) 31 Alexander Ct. Owings Mills, MD										
of He	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Demoved from St		Plece of Dispos cemetery, crem	ition (Neme of etory or other p	olece)	Data	20c. Location -	City or Town, State		
2 4 4 6				ke Vie	w Memo	orial	3-6-00	Elders	burg, MD		
Departm Departm Importar any inju	4 Donation 5 Other (Specify) Lake View Memorial 3-6-00 Eldersburg 21. Signment of Funeral Service Licenses 22. Name and Address of Facility										
Depariment of the part of the	21. Signature of Funeral Servica Lican Pritts Funeral Home and Chapel Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD										
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a	ong	. 1	201	1 +	50 0 -		1 .		
nsit miner		b	15 C	or es e consequ	uence of):	ent 1	autu		25 yr		
al-transit	Sequentially list conditions, if any, leading to immediate	C b	15 C	or es e consequ or as a consequ	uence of):	esc 1	am		25 yr		
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State of Maryland / Department of Health and Mental Hygiene

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•					Certificate	e of De	ath	Re	g. No.	0	0010) ()
)hualaian	_	. Decedent's Name (First, Middle, L	ast)					2. Date of Death Month	Dey	Year	3. Time of I	Death
Physician /Medical		OLLIE ROY						Februar	y 17,	2000	1:09	PM
Examiner		a. Facility Name (If not institution, go	and the second second					ocation of Death	4c. County			
	Į.	Washington Adver	-			100	coma Pa			gomer		
uneral rector	0	Social Security Number 6. 578–16–6811 Suel Residence of Decedent	Sex 7. Age	(In yrs. last I	Yrs. H Under Months		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day, Jan. 10	, 1914	9. Birthp Court Virg	place (State or ntry) ginia	Foreig
MON W	1	0a. Stale 10b. County		10c. City, To	wn or Location				904 00	1	0d. Inside City	/ Limit
r items 23a or 28a-f st niner must be notified Funeral Director	1	Maryland Prince Oe. Street and Number	Georges	Ade1p	hi 10f. Zip	Code		10	g. Citizen of V	What Cour	1 № Yes	2 🗌 N
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Eva by		1 Never Married 2 Married 3 Widowed 4 Divorced	13 Yes 2 No If Yes, Give Year or Dates: 0		42-	ny Cuban, M R No Sp		Hican, etc.)		ck, White, etc. y: Black		
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To Be Co		Welson Roy	,			10.		r's Name <i>(First, Middle, Maiden Sur</i> Cy Johnson			name)	
To	-	9a. Informant's Neme/Relationship	(Tyne Print)	11	9b. Mailing Address	(Street and			City or Tour	State 7in	Codel	-
		Sharon M. Bailey			06 Farada							
any injury or other	2	Oa. Method of Disposition		20b. Place	of Disposition (Nan tery, crematory or of	ne of	T	Dete 2	Oc. Location -	City or To	wn, State	-
7 04		1 XBurial 2 ☐ Cremation 3 € 4 ☐ Donation 5 ☐ Other (Spec			tico Nati		2	-25-00 T	rianol	e. Va		
2	-	1. Signature of Funeral Service Lice		quan				1 Home,		, ,,		
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unera unera Ion:	2	7. Manner of Death 1 Natural 5 Pending 2 Accident investigation	n	The impatient 2 LEW Outpatient 3 L DOA 4 L Nursing Ho			28d. Describe how injury occurred					
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completely filled in by Medical Certifi	2	9a. Certifier (Check only one) 15 Certifying Pl	nysician: To the best of niner: On the basis of e end menner stets	xamination e	ge, death occurred and/or investigation,	at the time, do	ate and plece, n, death occur	and due to the cer red et the time, de	use(s) and ma le and place,	anner as si end due to	tated. the cause(s)	
Comp	2	Bb. Signature and the of certifier				License nur		29	d. Date signer	d (Month.	Day, Year)	
2/	30	Name and address of person who	completed cause of dea	ith (Item 23a								
	1	LAMAN R.	TULI. N	11)		nector	m Dood	Coitha	rahura	MD		
State	3	Date filed (Month, Day, Year)	32. Registrar		10810 Dar	nescov	n Koad	, Gaithe	rsburg	, MD		
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17. Father's Name (First, Mode, Last) 17. Father's Name (First, Mode, Assent Surhama) 18. Marker's Name (First, Name, Assent Surhama) 18. Marker's Name (First, Name, Assent Surha		3 ☐ Widowed 4 ☐ Divorced			1 □ Yes	2LANo	Specify:						
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Type Part Locate Location	uple Men												
LEE ANDREW DICKERSON SR 19a. Informant's NamerRelationship (Type, Print) ARTHUR RED SR. / HUSBAND 20a. Method of Dipposition 11 Burial 2 Cremation 3 Demonstration 3					HOUSE	WIFE		da Alama					
19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stata, Zp Cot ARTHUR REED SR. / HUSBAND 2020 ALICE AVE # 103 OXON HILL, MD 20745			SON SR										
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22. Name and addigres of Earlilly 2-29-00 BRENTWOOD, M.	Hear 2							n, State					
21. Signature of Funeral Service Licenses 22. Name and Address of Excitive 538 MARLBORO PIKE, FORESTVILLE, MD 207 23a. Part. Enter the disease, or empiricaliens that coubid the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, Application of the part of the disease of conditions of the country of the part of	0 m o	1 W Buriai 2 Cremation 3 Chemoval from State											
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23a. Part Enter the disease, or considerations that couled the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, informatical conditions. Part I interest liabilities. List only enter cause on each line. 24a. Part I interest cause (Final dease or conditions contributing in death) 25b. Due to (or as a consequence of): 25c. Location (Sirger and Number or Rural Record) 25c. Was an autopsy performed? 25c. Was case referred to medical examined to graph of the exam	Physician //Medical indicate in the control of the	ALEXANDER'S . POPE FUNERAL HOME											
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D19431 FEBRUARY 29,2	3 - 8												
30. Name and address of person with completed cause of death (Itam 23a) (Type, Print)	(in)	30. Name and address of person with	ompleted cause of death /lte	m 23a) (Type	Print)		D194	31		FEBRUAR	Y 29,	2000	
30. Name and address of person with completed causa of death (Itam 23a) (Type, Print) FRANK RYAN M.D. FORT WASHINGTON HOPITAL DOCTORS BLD. FORT WASHINGTON MD	(10)					DOCT	ORS B	LD.	FORT WA	SHINGTO	N MD		

DHMH 16 Rev 6/95

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dical	PAULINE		BERTS				Month FEBA	Da	y Year 28 0000	9:50 AM
miner 4a Facility N	ame (If not institution) RS COMMUN					4b. City, Town	, or Location of D		County of Dea	
5. Social Sec 577-20 or 578-04	urity Number -1964 -7400	6. Sex 1 M 2 F	7. Age (In yrs. Ii 78	last birthday) If Ui Moni	der 1 Year hs Days		Hrs. 8. Date of (Month) JAN.	Birth , Day, Year)	9. Bir	thplaca (Stete or Foreig ountry) DRGIA
Usual Raside	nce of Decedent 10b. County		10c. City	, Town or Location						10d. Inside City Limit
MARYLA	ND PRINCE	GEORGES		BOW	IE					1XXYes 2□N
10e. Street a	nd Number			101	Zip Code			10g. Cit	izen of What Co	ountry?
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1 Neve	r Merried 2 Marriwed 4 Divorced	Armed Fo	orces? ▼⊠No	If Yes,	s 2 No	an, Mexican, F	Puerto Rican, etc.		Black, Whit	
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17. Father's i	WILLIAM	BOUYER	2			ETHI		E	EDWARDS	4 11/2
DEE	nt's Name/Ralationsl JENKINS/	DAUGHTER		19b. Mailing Add	IE BO		Y, UPPER	MARLE	BORO, MI	20774
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21. Signature	a cultureral Service I	EDWARI	M. DUD	DUIDI	EY FU	NERAL	HOME LAND AVE	МТ	DATNTI	ER. MD 207
Part1. shock,	Enter the diseese, or or heert feilure. List	complications that conly one cause on e	caused tha death	Do not enter the	node of dyi	ng, such es ca	rdiec or raspirate	ry arrest,	NATIVI	Approximata Intarval Between
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DHMH 16 Rsv 6/95

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State of Maryland / Department of Health and Mental Hygiene 08786 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Clifford PRJ541//
4a Facility Name (If not institution, give street and number) 0414 29 Feb 20,0 /Medical 4b. City, Town, or Location of Death 4c. County of Death Baltimore
If Under 24 Hrs. 8. Date
Hours Min. (Mo Bultimore City If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 F Months 220-66 - 8/86 Usual Residence of Decedent Director Washington DC 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 2 No Funeral Director MD Charles Charlotte hall 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code r than "natural", or items 23s or 20622 US permit. Pages 1 and 2 should be filed within 72 hours effer death v
Department of Health and Mentel Hygienn.
Important: If item 27 is marked other than "natural", or frama 23a
any Injury or other traumatic avent, the Medical Exemples must be bodg. 7250 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ Yo If Yes, Give Year or Dates: 1 ☐ Never Merried 2 Ø Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: p Specity: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Trade School Electrician Beltway Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) B John Paul Russell Dorothy Alice McMillan 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Debra Ann Russell (Wife) 9250 Trinity Church Rd. Charlotte Hall MD 20622 20b. Place of Disposition (Name of cemetery, crematory or other place) March 2, 20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20c. Location - City or Town, State 4 Donation 5- Other (Specify) Resurrection Cemetery 2000 Clinton, Maryland 22. Name end Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 M01095 au bed the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Septic Shock Examiner Physician/Medical Examiner Disseminated Fafectico Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Transplant recipient Division of Vital Records. by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? IMMUNUSUPPRESSION 1 ☐ Yes 2 № No 1 Yes 2 XNo or Attending Physician: 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 150 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2No this 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Netural 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) WIU 34149 Feb 28 2000 ss of person who completed cause of death (Item 23a) (Type, Print) UMMS 225. Greene St BAHmore MD 21201 A. MCARISEN M.D . Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

MAR 0 2 2000

Secret 1 2005 5 5 3005

3	Amend #2	6.Per Phys.	PGC 3-				tificate of	Death	лептат ну	Reg. No.	UU	08/8/
1		1. Decedent's Name (First							2. Date of Do	eath Day	Year	3. Tima of Death
	Physician /Medical	John W.	Rogers	3					Feb.		2000	3:58 P.M.
	Examiner	4e Facility Name (If not in						4b. City, Town, or L			ounty of Dea	
-		5. Social Security Number	-			. lest birthdey)	If Under 1 Year	Annapoli			ne Ar	
ı	Funeral Director	579 62 3960	3	□M 2□F	53		Months Days	Hours Min.	8. Date of Bi (Month, Di July 2	ay, Year) 4, 194	6 Ma	tholace (State or Foreign ountry) ryland
	syland show dat		County		10c. C	ity, Town or Lo	cation					10d. Inside City Limits
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	or 28a-f be notified Directo	10e. Street and Number					10f. Zip Code				n of Whet Co	
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020	with after death view 234 Examiner must by Funeral	11. Merital Status 1 Never Married 2 3 Widowed 4 C	Contract of	12. Was Dec Armed Fo 1 Yes J If Yes, Gr Yaar or D	XZ ONo		Vas Decedent of F t Yes, specify Cub	dispanic Origin? (Sp an, Mexican, Puerto Specify:	Bican, etc.)		Bleck, Whit	white
Maryland 21215-0020	ed within 72 ho yglens. wer than *naturn it, the Medical.	15. C (Specify on Elementery/Secondery)		ucation de completed) College (1-4or 5+)			pation during most of work d)	ing		of Business	
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altimore,	Page mant of ant: If I	1 ☑ Burial 2 □ Cred 4 □ Donetion 5 □ C			Siele	ort Lin	coln Cem	etery	I F f L			Maryland
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	/Medical Examiner	Immediate Cause (Final diseese or condition			LUNG	- CA	NER					Honort
		resulting in deeth)			Due to (or es a conseq	uence of):					
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	be executed iclan and burial-transit	Sequentially list condition if any, leeding to immedia cause. Enter Underlying Cause (Disease or injury that initieted events	is, ete		Due to (or as e conseq	uence of):					
68760,	D DO D	Cause (Disease or injury that initiated events	~	c	Due to /	or as a consequ						
	= -= 4	resulting in deeth) Last	ı	4	Oue to (or as a consequ	dence or):					
Box	death certified at the attending and for use at the ticlan/Me	Part II. Other algnificant	onditions of	notributing to de	eath but not re	sulting in the ur	dertving cause on	ven in Pert I	23h Did	Johacco ua	a contribute	to the cause of death?
P.0	by the sache			in locality to de	outh out not roll	soung in the di	out on yang out oo o		12	Yes 20		robably 4 Unknown
ords	v requires that been signed should be del								24a. Wes	an autopsy	24b.	Were autopsy findings available prior to
Records,	has b					7.1						completion of cause of death?
	certificate ha rector, page	25 Man	Al1							Yes 2	No	1 Yes 20 No
of Vital		25. Was case reterred to examiner?	7.000.00	Hospital:		<i>i</i>	Ott	26. Place of Deet	1/		70" "	- 4 .
	E 2 = -	1 Yes 2 No			of Injury	ER/Outpatien 28b. Time of	T BLI DOA	4 LI Nursing Ho	28d. Describe		Other (Spe	icity)
O.	ding Ph. Th. After th. Iuneral	1 Netural 5 -	Pending investigation		of Injury th, Dey Year)	Injury	M 1	rk? Yes 2 □ No				
Division	tal or Attending P is after death. al Director: After ti led in by the funera Certification:	3 ☐ Suicide 6 ☐	Could not be	28e. Plece	of Injury - At h	ome, ferm, str	eet, fectory, office				Number or R	ural Route Number,
Š	after Direction din the	4 Homicide	Gotominoa	buildi	ng, etc. (Speci	<i>(y)</i>			City or To	wn, Stete)		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certifical	(Check only 2 N	Certifying Phy ledical Exam	Iner: On the bi	asls of examina	owledge, deeth	occurred at the tirestigation, in my c	me, date and place, opinion, death occur	and due to the	cause(s) an	nd manner a	s stated. e to the cause(s)
	within 2 To the comple	29b. Signature and little of	Antifier C	end men	ner stated.		29c, Licens	se number		29d Date	signed (Mon	th, Day, Year)
	TWT 8	b	Jack	(La	Jula	\	2.50. Eldens	1/22/1		2	2-1	100
	(0)	76	sa s	Mak	KMI)	<u> </u>	TUCUI		21	77 10	10
	(8)	PETER R	(John	E MI	900	m 23a) (Type,	ate Rd	#300	Ann	ocpol	5	(40)
	State Registrar	31. Date tiled (Month, De)	1 200		egistrar's Sign	S.	Spark	,		1		

DHMH 16 Rav 6/95

Walnut Kling

MAH 0 1 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 008788

			unicate of	Dealli		Reg. No.						
	Physician /Medical	1. Decedent's Name (First, Middle, Last) Andrew M. Rocker, Sr. 4a Facility Name (If not institution, give street and number)						Month Februar	ebruary 28 2000		3. Tima of Death 7:25 pm	
2	Examiner						4b. City, Town, or Location of De		ath 4c. County of Death			
F	uneral	Prince George's 5. Social Security Number	Age (In yrs. last b	a (In yrs. lest birthdey) If Under 1 Yrs. Months De		Chever				ce George's 9. Birthplace (State or Foreign Country)		
D	irector	216-14-7544	216-14-7544 ¹ ₹ ^M ^{2□} F			110013			0, 1921 Marylan			
2	,	Usual Residence of Decedent 10a. Stete 10b. County	10a City To	y, Town or Location				10d Incide Clin Lie		Od Inolda City Limita		
e Maryla	and show					nar Manor					0d. Inside City Limits 1 ☑ Yes 2 ☐ No	
E E	at, or items 23s or 28s-f show Examiner must be notified at by Funeral Director	10e. Street and Number 10f. Zip Cod							10g. Citizen of	10g. Citizen of Whal Country?		
*		3800 Newton Street 20722						U.S.A.	J.S.A.			
21215-0 d within 72 ho giene. or then "netur	r flore 23	11. Merital Stetus 12. Was Decedent Ever in U,S Armed Forces?			13. V	Vas Decedent of F Yes, specify Cub	Hispenic Origi	n? (Specify Yes or N Puerto Rican, etc.)		ck, White,		
	Energy H	1 ☐ Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:			1 ☐ Yes 2 ☒ No Specify:				Specify: White			
		15. Decedent's Education (Specify only highest grade completed)			16e. Decedent's Usuel Occupetion (Give kind of work done during			tion		16b. Kind of Business/Industry		
			Elementary/Secondery (0-12) College (1-4or 5-		life. DO NOT use re			ired)		Gas Station and		
	O P	12							Towing Service			
	2 0	17. Fether's Neme (First, Middle, La					s Neme (First, Middle	Maiden Sumeme)				
S should be	Tic of	Charles Rocker	harles Rocker				Louis	e Barnard				
Maryland	7 la marke traumatic TO	19a. Informent's Name/Reletionship	19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Stre					reet end Number or Rurel Route Number, City or Town, Stete, Zip Code)				
		Andrew M. Rocker	, Jr Se	on 3	714	40th Pla	ace, Brentwood,		Maryland 20722		22	
os 1.	, E 0	20e. Method of Disposition		com of	Plece of Disposition (Neme of cemetery, cremetory or other p		ice)	Dete	20c. Location	- City or To	own, Stele	
E 6 5	unt: H	1 M Buriel 2 Cremetion 3 4 Donetion 5 Other (Spe	10	Fort Lincoln Cer			03/03/00	Brentwood, Maryland				
Bailti Permit.		21. Signeture of Funeral Service Licensee 22. Name and Ado										
n a	any l	Gasch's Funeral Home, P.A.										
/		23a. Perti. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest. Approximate										
	/sician	shock, or heert teilure. List only one cause on each line. Interval Between Onset and Deeth										
	ledical aminer	Immediate Cause (Final disease or condition resulting in death) e. IMBIABOLIC ACIDOS S										
D	in in	Sequentielly list conditions. Due to (or as a consequence of): Due to (or as a consequence of): Due to (or es a consequence of): CROHN'S DISE ASE										
ox 68760, certificate be executed iding physician and ise es the burial-transit	an and rial-transit Examiner	Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or es a consequence of): CROHNS DISE ASE Due to (or es a consequence of): CROHNS DISE ASE										
	hysici he bu	Cause (Disease or Injury that Initiated events resulting in death) Last Due to (or es e consequence of):										
oertifica	Se es	d										
deeth cert	6 3											
o the second sec	ys.	Pert II. Other eignificant conditions contributing to death but not resulting in the underlying couse ODIBLIES MELLITUS (2) CAR					ven in Pert I.		d tobacco use contribute to the cause of death			
							PYTH	IMMS 10	Yes 2 No 3 Probably 4 Unknow			
OT VITAL MECONDS, P.O. Physicien: The lew requires that the	page 2 should be det	3 CORONARY ARTERY DISEAS					TER	24e. We	s en autopsy formed?	av	ere autopsy findings allable prior to empletion of cause	
The lew		4 DIABETIC NEUROPATHY (5)					LEMOSURAD.		Yes 2 No	of deeth?		
- E	certificate rector, pa	25. Wes case reterred to medical 26. Place of Death (Check only one)										
		exeminer? 1 Yes 20 No										
		27. Menger of Deeth 28e. Dete of Injury 28b. Time of 28c. Injury et 28d. Describe how injury occurred										
	atio	1 Naturel 5 Pending (Month, Dey Year) Injury Work? 2 Accident Investigation M 1 Yes 2 No										
OIVISION I or Attending	al Director: After ted in by the funeral Certification:	3 Suicide 6 Could no 4 Homicide determin	28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)					28f. Location City or 7	28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)			
To the Hospital or within 24 hours after	To the Funeral Director: A completely filled in by the funeral Medical Certification	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the fime, dete end place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated.										
thic	Med Med	29b. Signeture end-title of certifier 29d. Date signed (Month, Day, Year)										
1	84	MOKAMMER A. MAMMAN MD. D24593 2,29,00.										
(30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print), 3331-TOLEDO TERRACE, MD, 20762										
	State Registrar	31. Dete filed (Month, Dey, Year) MAR 0 1 2000	82. Regis	strer's Signeture		land.	1					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Lest) 2. Date of Daath ^{Day} 2000 Month **Physician** FIETTA K. ROSENBERGER 1, MAR. 4:25 PM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL LUTHERAN HOME MONTGOMERY ROCKVILLE 5. Social Security Number If Under 1 Year If Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) 1□ M 2√F Days 066-09-1905 94 Yrs. Director OCT.7,1905 VIRGINIA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits be notified at MD. MONTGOMERY ROCKVILLE Director X ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 9701- VEIRS DRIVE 20850 USA "natural", or items 23a death Funeral 12. Was Dacadent Ever in U,S. Armed Forcas? 1 ☐ Yas 3 TNo if Yes, Give Yaar or Dates: Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, White, etc. 11. Marital Status filed within 72 hours after Naver Married 2 Married 21215-0020 1 ☐ Yas 2 ☐ No Specify. by Specify: 3 Widowed 4 Divorced WHITE Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Peges 1 end 2 should be filed within ment of Health and Mental Hygiene. Int: If item 27 is marked other than ury or other traumatic event, I'm M ADMINISTRATIVE NURSE NURSING 12 Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be CHARLES M. ROSENBERGER JEANNETTE M. SMITH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) THOMAS ROSENBERGER 1998-BLACK MOUNTAIN RD., WINCHESTER, VA. 22602 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burlei 2 Cremation 3 Removal from State permit. Pege Department important: If any Injury or 4 ☐ Donation 5 ☐ Othar (Specify) ST.JOHNS LUTH.CEM 3/4/2000-WINCHESTER, VA. 21. Signature of Funeral Son ice Licensee 22. Name and Addrass of Facility W. m. lan HYSONG CO., INC. s that caused the death. Do not entar the mode of dying, such as cardiac or faspiratory arrest, DC se on each line. Approximata intervel Betw Onsat and Death **Physiclan** Immediate Cause (Final disease or condition resulting in deeth) /Medical neumonia Examiner Due to (or as a consequence of) reimers The few requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last pue Due to (or as e consequence of) Box 68760, physician Physician/Medical the Dua to (or as a consequence of) for use es P.O. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 3 No 3 Probably 4 Unknown Records, à 90 Completed 24b. Were autopsy findings available prior to completion of causa of death? 24e. Wes an autopsy performed? Deen certificate has 2 1 No 1 ☐ Yes 2 ☐ No of Vital Attending Physician: director. Be 25. Was casa referred to medical 26. Place of Death (Check only one) 9 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA s efter death.

I Director: After this of in by the funeral d this Certification: 27. Manner of Deeth 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Division 1_Naturai 5 Pending investigation 1 Yes 2 No 2 Accident 3 Sulcida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Placa of injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide ò Hospital To the Hospital within 24 hours To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, end due to the ceuse(s) end manner as stated.
2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and dua to the causa(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

Registrar

State

31. Data filed (Month, Day, Year) MAR 0 3 2000

s of person

32 Registrar's Signature

ompleted cause of death (Item 23a) (Type, Print)

Drive, Germantoun

MAR 0 3 2000 planes & special

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month Physician February Redd 27 2000 4:30 PM Sherman E. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glenburnie Ann Arundel Mariner Health Center If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 100 M 2□ F 67 Director 579-38-1934 July 11 1932 Wash., D.C. Usual Residence of Dece 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location r than "natural", or frame 23a or 28a-f ahow the Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland Prince Georges Brentwood 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 3930 Allison Street permit. Pages 1 and 2 should be filed within 72 hours aftar death.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or forms 284 and Injury or other traumatic avent, the Marical 20782 U.S.A. 12. Was Decedent Ever in U,S. Apped Forces? 1 △ Yes 2 □ No 1958 If Yes, Give Year or Dates: 1960 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: Black P 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Basilica Of The Nat'l Elementary/Secondary (0-12) College (1-4or 5+) Shrine Imma culate Conc 10 Security Baitimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cometery, crematory or other place)

Additional Place of Disposition (Name of cometery, crematory or other place) Sherman E. Redd Jr. (Son) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Memorial Cemetery3/4/00 Suitland, Maryland 21. Signature of Edneral Service Coenses 22. Name and Address of Facility Rendon/Hale Funeral Home Paul. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Cellowooder oreider Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an eutopsy performed? Completed Chemia 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this cardific completely filled in by the funeral director, 89 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D-40521 February 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7845 Oakwood Roa ie, hD 21061 OCHANE 2. Registrar's Signature

DHMH 16 Ray 6/95

State

Registrar

31. Date filed (Month, Day, Year)

MAR 0 1 2000

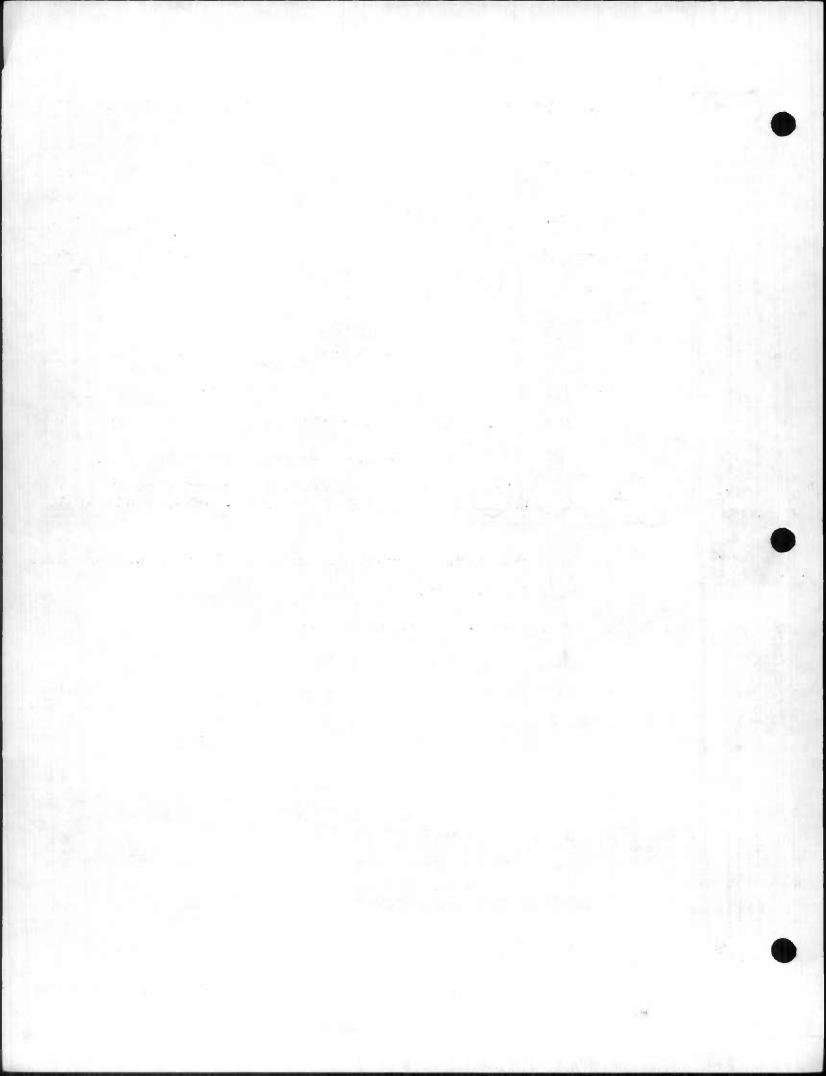
MAR \$ 1 2005 Comments

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State of Maryland / Department of Health and Mental Hygiene 00879

		Decedent's Neme (First, Mich.)	idle, Last)		Cel	rtificate of	Dealii	2. Date of Dea			ima ot Death	
Physic /Med		LOUELLEN	SUMMERS					Februa	ry 27	2000	2322	
Exami		4s Facility Neme (If not institut	ion, give street end n	num <i>ber</i>)			4b. City, Town, or	Location of Death	4c. County	of Death		
		Union Hosp	pita1				E1kt		Ceci	.1		
Funeral Director		5. Sociel Security Number 222–24–5530	6. Sex 12X M 2 □ F		58 Yrs.	If Under 1 Year Months Deys			1941	9. Birthplace (Country) Delawa	Stete or Foreign	
land wa		Usuel Residence of Decedent 10a. Stete 10b. Court	ity	10c. C	ity, Town or Lo	cation				10d. In:	side City Limits	
Many Heat	to	MD Ce	eci1		Cecilt	con				th	Yas 2□No	
h the	Director	10e. Street and Number	THE RESERVE			10f. Zip Code			Og. Citizen of \	What Country?		
th wit	a D	160 Church	h St.			2191	3		U.S.A.			
5-0020 72 hours effer death with the Maryland natural, or Nama 23a or 28a-f show alcal Examiner must be notified at	by Funeral	11. Meritel Stetus 1 Never Married 2 M M 3 Widowed 4 Divorce	erried Armed (Wes Decedent of If Yes, specify Cub	en, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		e - American Indick, White, etc.		
	Completed	15. Deced (Specify only high Elementery/Secondery (0-12	ent's Education hest grade completed	d) (1-4or 5+)	(Give		during most of wo ad)	orking		usiness/Industry		
a filed within It Hygiene.		10 17. Fether's Name (First, Middl	in A noti		Truc	k Drive		ma (Circt Middle	Truck			
Marylanc 2 should be fi 3 and Mentel H 16 marked out	Be C	John Summer						ome (First, Middle,	viationi Surrien	10/		
should and Men or marks	To	19a. Intormant's Name/Reletio			19b. Meilir	ng Address (Stree		Ta 1000	r. City or Town.	State. Zip Code)	
		Blanche Sum		(wife)		. Box 3		cilton,				
9 - 3 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4 - 4		20a. Method of Disposition		20b.	Place of Dispo	esition (Neme of metory or other ple		Dete		City or Town, S	tete	
Pages nent of nrt: If the rry or o		1X Burial 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other		m Stete				y 3/4/0	O Ceci	lton,	MD.	
Baltimore, permit. Pages 1 ar Department of Hea Important: if frem 2 eny Injury or other page.		21. Signeture Furneal Service Location M00510 M00510 M00510 M00510 22. Name end Address of Fecility Galena Funeral Home of Stephen Sch 118 West Cross St. Galena, MD. 216										
Physician /Medical Examiner		23a. Inter the disease, sworth or heart failure. Li Immediate Cause / inel disease or condition resulting in death)		lseles		trical		ty of t		Onse	nutes	
rificate be stacuted ing physician and as the buriel-trensit	Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last	c. Meta	Due to	or es e consequence Canc or es e conseque	er to	ent the Bra	in		1		
death certif	Physician/M		d									
the de	ysic	Part II. Other significant condi	tiona contributing to	death but not re	suiting in the u	nderlying cause gi	ven in Pert I.	23b. Dld t	obacco uan co	ntributa to the c	auss of death'	
7 5 5 5								1301	aa 2 No	3 Probably	4 🗌 Unknow	
need should	Completed by							24a. Wes a perfor		24b. Were au available completi of death	prior to on of cause	
	Fo							1 🗆 Y	es 2M No	1 Yes	2 No	
Physicien: The this certificate rai director, pag	Be	25. Was case referred to medic	cel				26. Place of De	eth (Check only o	ne)			
Physicien: this certific rai director,	To	exeminer? 1 Yes 20 No	Hospitel: 1	Inpatient 2D	ER/Outpatier	nt 3 DOA	her: 4 Nursing	Home 5 ☐ Resid	enca 6 □Oth	er (Specify)		
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	Z C ACCIONIN	ding (Mo	e ot Injury onth, Day Year)	28b. Time of Injury	Wo	ny at ork?] Yes 2 ☐ No	28d. Describe h				
Is a therd	Certifi		minor 200. Ple	ce of Injury - At I Iding, etc. (Spec	nome, term, str ify)	eet, tectory, office		28f. Location (Street and Number or Rural Route No City or Town, State)			le Number,	
Hospi 24 hou Funer. etely fill	edical		ring Physician: To the al Examiner: On the and ma								ause(s)	
2 6 2 5	Σ	29b. Signeture and Itie of cartif	1			29c, Licen			29d. Date signe	d (Month, Day, 1	(ear)	
To the Within To the comple		11/1 -	hard N302				130291 2/29/00					
To the complete		1/1 au	en or			133	CATI		12	7/00		
To the Comple		30. Neme and address of permanents D	enitzio			Print)	-	Cecilton	MD	21012		

DHMH 16 Rav 6/95



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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Year Physician Samuel H. Sandidge 02 9:23 AM 21 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Deeth **Examiner** AA County Glen Burnie North Arundel Hospital If Under 24 Hrs. If Under 1 Yeer 6. Sex 1₽ M 2□ F 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days Months Hours Yrs. Director 62 09-17-1937 577-52-2844 Virginia Usuai Residenca of Deceden 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-t show be notified at Prince George's Lanham 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 5646 Whitfield Chapel Road, #302 20706 Nerve 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. hours after 1 Never Married 2 Merried Specify: Black 8 Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: ğ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Private Truck Driver 11th 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) peimit. Pages 1 and 2 ahould be fit Department of Health and Mental H Important: If item 27 is marked oth any injury or other traumatic even Be Rosa Hamlet Charles Sandidge 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) 5646 Whitfield Chapel Road, #302 Jacqueline Blair/Friend 20706 20e. Method of Disposition

1 Buriel 2 Cremetion 3 Removal from State 20b. Place of Disposition (Nama of 20c. Location - City or Town, Stete Cemetery, cremetory or other place)
Maryland Veterans 02/28 4 ☐ Donetion 5 ☐ Other (Specify) Cheltenham, Maryland 21. Signeture of Funeral Service Licansee 22. Name and Address of Fecility J.B. Jenkins Funeral Home 20785 Maryland Nancu 7474 Landover Road, Landover, ler cen he 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel Aspiration Pneumonia diseese or condition resulting in deeth) Examiner Due to (or as a consequenca of): Chronic Renal failure The law requires that the deeth certificate be executed and burial-tran Sequentially list conditions, if any, teading to Immediate cause. Enter Underlying Ceuse (Diseese or Injury thei initiated events resulting in deeth) Lest Due to (or as a consequenca of) physician s the buria Box 68760. Diabetes Mellitus Physician/Medical Due to (or as a consequence of): 88 980 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other algnificent conditions contributing to death but not resulting in the underlying cause given in Part t. 1 Yee 2 No 3 Probably 4 Unknown should be det Records, by 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? page 2 1 Yes 2N No tX Yes 2 □ No certificate of Vital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only ona) Hospitel: X Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 27. Manner of Death 1 Neturet 28a. Dete of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation After Division 1 Yes 2 No 24 hours after deeth. 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 | Homicide filled in Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dele and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and places, and due to the cause(s). Medical 29e. Certifier (Check only within 2 To the f \$ 29c. License number 29d. Dete signed (Month, Day, Year) 29b. Fignature and FEBRUARY 28, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE GLENBURINE, MI MALKIEL MIMPEUS 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State FEB 2 9 2000 Registrar

DHMH 16 Rev 6/95

FEB 28 2520 James & James

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State of Maryland / Department of Health and Mental Hygiene

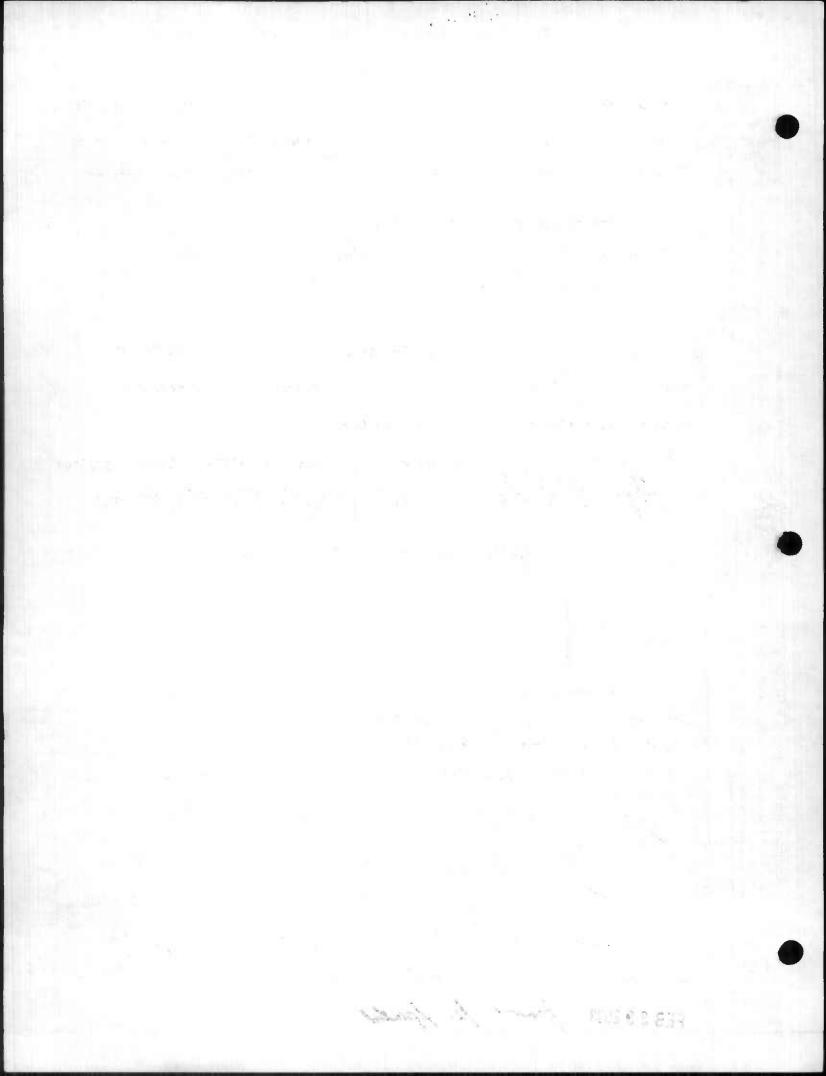
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				Ce	rtifica	te of	Death			Reg. No.			
_	Decedent's Nama (First, Middle, L	ast)							2. Date of De	_	Vene	3. Time	of Death
ician	Sara		Shar	iro					Februa	ry 19,	2000	3:	10 AM
dical 48	Facility Name (If not institution, gr	ive street and nur	nber)			4	b. City, To	own, or Lo	ocation of Death	4c. County	of Death		
ici	Potomac Valley	Nursing	Center				Roc	kvil	le	Mon	tgome	ry	
5.	Social Security Number 6.	Sex	7. Age (In yrs.	last birthday)		er 1 Year	If Under		8. Date of Birt	th		-	te or Foreign
5	79-18-7300	1□M 2\(\overline{A}\)F	79		Months	Days	Hours	Min.	Dec. 1	y. Year) 4, 1920		ny) cnow	
U	sual Residence of Decedent								1	+, 1920	COLLE	CIIO W.	11)
10	Da. State 10b. County		10c. Ci	ty, Town or Lo	ocation						10	d. fnside	City Limits
M	Montgo	omerv				F	Rockv	ille				101	as 2 No
-	De. Street and Number				106.7	io Code				10g. Citizen of V	What Count	n/2	
1		.11 D.1			101. 2		0000						
-	1234 Potomac Va						20850				ed Sta		
11	I. Marital Status	Armed Fo		,S. 13.	Was Deci	ecify Cuba	ispanic Or in, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	- 14. Hac	e - Amarica k, White, e		,
	1 Never Married 2 Married	1 Yes	2 No		1 🗆 Yes	2 ☑ No	Specify:			Specify	e: 1	Whit	P
	3 Widowed 4 Divorced	Year or D	ates:			22						WIII. C	
	15. Decedent's E (Specify only highest gi			16a. Dece	kind of w	ork done i	durina mas	at of work	ina	16b. Kind of Bu	siness/Ind	ustry	
	Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT	use retired	1)						
	12			(Unkn	own)				Health	Asso	ocia	tion
17	7. Father's Nama (First, Middle, Las	it)					18. Moth	er's Name	e (First, Middle,	Maiden Sumam	10)		
	(Unknown)						(Uni	knowi	n)				
15	9a. Informant's Name/Relationship	(Type, Print)								er, City or Town,		Code)	
	Patricia M. Wild	zek/Gau	rdian	Mont	gome	ry Co	Hea	alth	& Human	n Servic e, MD 2	ces		
-	a. Method of Disposition		20b. F	Place of Dispo	sition (Na	ame of		1	Date	20c. Location -	City or Tov	vn, State	
	1 ☐ Buriat 2 ☐ Cremation 3 I		State .	cemetery, cree esapeal					eb. 26				
_	4 Donation 5 Other (Special		CIII					1	2000		svill	e, M	ID
2	Signature of Funeral Service Lice	nsee		4	app	Pune.	san ad	nd C	rematio	n Servi	ces		
											209	10	
2	 Part1. Enter the disease, or con shock, or heart failura. List only 		aused the deat								,	Approxi	nate Between
EXAMILITY OF CHARLES	esulting in death)			organ							1	5 6	lays
S	equentially list conditions,	Due to (or as a consequence				ence of):							
CE	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury		Malnutrition & Dehydra				ratio	n				1 n	onth
U	at initiated events sulting in death) Last	С.	Dua to (or as a consequence of):										
"		Multiple Chronic Diseases						1					
		d					1						
Pa	art ff. Other algnificant conditions	contributing to de	eth but not res	ulting In the u	n the underlying cause given in Part I.				23b. Did tobacco use contrib			the cau	se of death
				3	g	giv	The same of			Yea 2□No			Unknow
_										- TO 140			25 3
										an autopsy			sy findings
_										rmed?	con	ilable pri	or to of cause
											of d	leath?	1.61
									10'	Yes 2⊠No	10	Yas :	2□ No
25	Was case referred to medical axaminer?							e of Deat	h (Check only o	one)			
	1 ☐ Yes 2 ☒ No	Hospital: 1 🗆 I	npatient 2	ER/Outpatier	nt 30 C		ক হৈছি ।ব।	ursing Ho	me 5 Resid	dence 6 Oth	er (Specify)	
27	'. Manner of Death 1 ØNatural 5 ☐ Pending	28a. Date of	n Injury h, Day Year)	28b. Time of Injury	1	28c. Injur	y at k?		28d. Describe I	how injury occur	red		
	2 ☐ Accident investigation	on			М		Yes 2□	No					
	3 Suicide 6 Could not 8 determined	288. Place	of Injury - At h	ome, farm, str	eet, facto	ry, office			28f. Location (: City or Tox	Street and Numb	er or Rural	Route N	lumber,
		Ounqu	ig, etc. (Specil	,,					July 01 101	, 01210)			
29	ea. Certifier 1 Certifying P	hysician: To the	best of my kno	wiedge, death	n occurre	at the tin	ne, date an	nd place,	and due to the	cause(s) and ma	nner as sta	ated.	
	(Check only 2 Medical Exa	miner: On the ba and mann	sis of examina er stated.	tion and/or in	vestigatio	n, in my o	pinion, dea	th occurr	red at the time,	date and place,	and due to	the caus	se(s)
29	b. Signature and title of certifier	10 1		11	29	c. Licens	e number			29d. Date signe	d (Month, E	Day, Yea	r)
	b /1//	1	/ /	/	2		D5220	61					
_	(lean)	X	angi	n	/					Februa	iry 15	, 4	000
30	. Name and address of person who		1										
	Alan R. Segal M.	D., 129	9 Lambe	rton D	r.,	Silve	er Sp	ring	, MD 2	0902			
	Data filed (Month, Day, Year)		egistrar's Signa		r.,	SIIVE	er Sp	ring	, MD Z	0902			

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08794

	_										Reg. No.				
Dhuelel		Decedent's Name (First, Middle								2. Dete of D	eeth	,	Van	3. Time	of Death
Physici /Medio		Richard Storty	1							Month 02	25	2	2000	8:0	00pm
Examir		4e. Fecilify Neme (If not institution	n, give street end nu	mber)	- de-			4b. City, To	own, or Lo	ocation of Dee	th 4c.		of Deeth		
		Villa Rosa Nurs	ing Home					Mitch	ellv	ille	Pr	ince	e Geo	rges	
Funeral		5. Social Security Number	6. Sex	7. Age (In yr	rs. last birthd			If Under	24 Hrs.	8. Date of B	irth				e or Foreig
Director		220-34-3436	1 M 2□ F	1	.01 Yrs	Months	Deys	Hours	Min.	Jan. 1	. 189	9	Mary 1	and	
		Usual Residence of Decedent								Juli 1	, 10)		MIL J M	and	
Mo H		10e. Stete 10b. County		10c. (City, Town or	Location							10	d. Inside	City Limit
12	to	Maryland Prince	Georges	Te	emple 1	Hille				1 □ Yes 2 □ 1				98 2 N	
288	Directo	10e. Street and Number	ocor geo		inpice i	10f. Zip	Code			10g. Citizen of Whet Country?				Λ	
3a o		5757 Fisher Roa	d			207	48			USA					
Separtment of Health and Mental Hygiene. Important: If Item 27s or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Maritel Stetus		edent Ever in	U.S. 1			Hispenic Or	igin? (Sp	gin? (Specify Yes or No-					
to de	Für	1 ☐ Never Married 2 Marri	Armed Fo	orces?		If Yes, speci	ify Cub	an, Mexica	n, Puerto	Rican, etc.)	Bleck, White,		k, White, e	itc.	
1,0	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi	ve		1 ☐ Yes 2	≥⊠ No	Specify:				Specify.	Whit	е	
three market		15. Decedent		0,00	16a De	cedent's Usue	Occur	netion			16h Kir	nd of Ru	siness/Ind	uetni	
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thar	E	Elementery/Secondery (0-12)	College (1-4or 5+)		E-Emplo					Pawn	Bro	ker		
at a	ŭ	17. Fether's Name (First, Middle, I	(get)		DCL		,	_	orla Nama						
d of	Be	_						18. Mother's Neme (First, Middle, Maiden Surneme)							
Merke	2	Frank		Storty			Nuncio				Bona				
is m		19e. Informent's Name/Reletionsh			19b. M	eiling Address	(Street	t end Numb	er or Rure	el Route Num	ber, City or	Town,	Stete, Zip	Code)	
m 27		Margaret Storty	/Wife			e as it		10							
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Year 22 12:50 AM 2000 4a Fecility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death HOWARD COUNTY GENERAL HOSPITAL COLUMBIA If Under 24 Hrs. Hours Min. HOWARD If Under 1 Yaar 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Steta or Foreign Country) 5. Social Security Number 6. Sex Months Days 1□M 20 F Yrs. 88 JUN 30, 579-52-6140 1911 WASHINGTON, DC Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ¥ Yas 2 □ No MARYLAND HOWARD COLUMBIA 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 7070 CRADLE ROCK WAY #228 21045 U.S.A. 12. Was Decedent Evar in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 1 ☐ Yes 2 No If Yes, Giva 1 ☐ Never Married 2 ☐ Married 1 ☐ Yas 2 No Specify: Specify: CAUCASIAN 3 K Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 TELEPHONE OPERATOR U.S. GOVERNMENT 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) ED RAMEY LULA IRENE LATHAM 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) CHARLES F. CASE (SON-IN-LAW) FULTON, MD 8157 MURPHY ROAD 20759 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 Burial 2 □ Cremation 3 □ Removal from Stata 4 □ Donation 5 □ Other (Specify) FAIRFAX MEMORIAL PARK 02/24 FAIRFAX, VIRGINIA 22. Nama and Address of Facility DEMAINE FUNERAL HOMES, INC. 21. Signature of Funaral Service Licensee enton 5308 BACKLICK RD. SPRINGFIELD, VA 22151 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failufa. List only one cause on each lina. Approximate Interval Batween Onset and Death 48h Immediate Cause (Final disease or condition rasulting in death) toutu Dua to (or Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

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page 2 certificate has

funeral director,

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After

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edical Certification: To

The law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

or Attending Physician:

Oppartment of Important: If any injury or other

Physician

/Medical

10e. State

Director

Funeral

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Completed

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Examiner

Funeral

Director

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the Mentand

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filed within 72 hours effer

I Hygiene. other than

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21215-0020

Baltimore. Maryland

Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Completed by

25. Was case referred to medicat examiner?

1 Yas 2 No

4 Homicide

29a. Certifie

3 Prebably 4 Unknown 1 | Yes 2 | No

24a. Wes an autopsy performed? 2000 1 ☐ Yas

24b. Wera autopsy findings available prior to complation of causa of death?

26. Place of Death (Check only ona)

1 ☐ Yas 2 ☐ No

		Ed. 1 Red of Doutin Cond only only								
Hospital:	1 Opatient	2 ER/Outpatient	3□ DOA	Other:	4 Nursing H	oma	5 Residence	6 Other (Specify,		
28a.	Date of Injury	28b. Tima of	28c.	Injury at		28d.	Describe how inj	ury occurred		

28a. Date of Injury (Month, Day Year) 5 Pending invastigation Work? 1 Yes 2 No

27. Manner of Death Netural 2 Accident 8 Could not be 28e. Place of thiury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street and Number or Rurel Route Number, City or Town, Stata)

To Cartifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

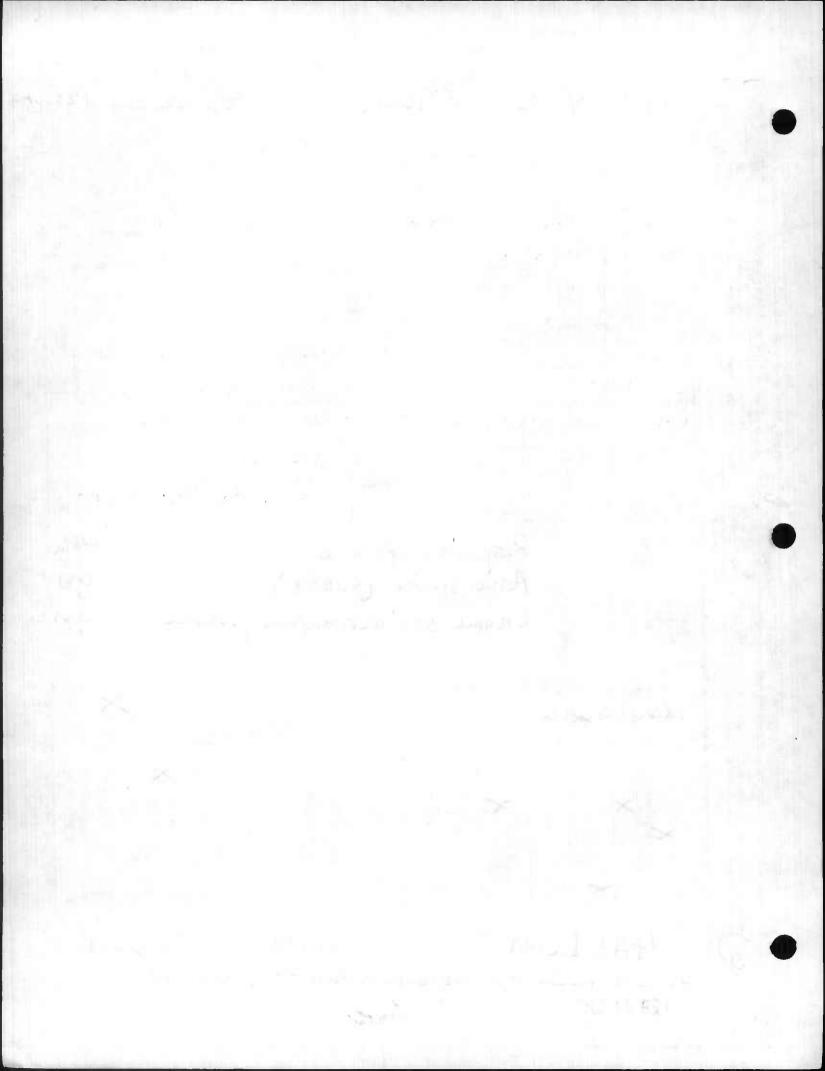
(Check only one) 29b. Signature and titla of certifie 29c. License number 29d. Data signed (Month, Day, Year)

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

H.A. OKEN 3460 ELICOT COTEN & NEVETERS ELICOT CITY ND 21043

State Registrar

32. Registrar's Signatura



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

				State of N			tificate of	Death		Reg. No.	00	00130			
	Dhunining		Name (First, Middle,	Last)					2. Date of De	path Day	Year	3. Time of Death			
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	Examine	4- 5100 - 0.5-	me (If not institution,	give street and number	r)			4b. City, Town, or I							
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-	6 8 6						10f. Zip Code			10g. Citizen of	what Cour	ntry?			
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DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08797.

				Certifica	ate of	Death		Reg. No.			
	1. Decedent's Name (First, Middle	Last)						2. Dete of Deeth Month Dey Year		3. Time	of Death
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Funeral Director	214 58 4968	6. Sex 1 □ M 2 □XF	Age (In yrs. last 48	birthdey) If Und Yrs. Month	der 1 Year ns Deys	If Under 24 Hrs Hours Min	(Month Di	11, 1951	9. Birthp Coun Mar	place (Stete stry) yland	or Foreign
P .	Usual Residence of Decedent 10a. State 10b. County		10c City To	own or Location					1	10d. Inside	City Limits
Asyla de la se		Arundel									s 2ANO
or 25a-f sho be notified a	MD 10e, Street and Number		Shac	dy Side	Zip Code			10g. Citizen of Whet Country?			AA
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South The 2	11. Meritel Stetus	12. Was Deceder	nt Ever in U,S.	13. Was De					. Race - American Indian,		
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Depart Depart Import any inj answ	21. Signature of Funeral Service L	Inc Maryl	6633 and 2	01d 10735							
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To the Hospital or within 24 hours after To the Funeral Director completely filled in Medical Cert		Physician: To the bes									9(s)
the thin 2, the part of the pa		and manner									
or or or or	29b. Signature end title of certifier	11-	Mealth	21 0-1	29c. Licens	e number	2	29d. Date signe	ia (Month,	Day, Year)	/
	30. Name and address of person MA IC) Y M1 'CI	1-1.	1 00100	u mocho	F	1559	2	7 FBRU	MIZY	155	2000
	30. Neme end address of person	no completed cause of	death (Item 23)	B) (Type, Print)	~	CM NON	LUR	/2	h 1 114	ONI	4
	MAKIYMI'CI	AN KAL	MUBO	- 7			10012	ISHL	1117	011)	
State	31. Date filed (Month, Day, Year)	32. Regis	trar's Signature	land.	,						

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 8798 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 256 FEBRUARY Scales, 27,2000 LeRoy III 4c. County of Death 4b. City. Town, or Location of Deeth 4e Fecility Name (If not institution, give street and number) GEORGES HOSPITAL CENTER If Under 24 Hrs. GEORGES PRINCE PRINCE If Under 1 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) Months Deys Houra Min. 1X) M 2□ F June 19, 1952 Wash., 578-70-6910 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 W Yas 2 □ No Capital Heights Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6926 Aquamarine Court 20743 IISA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marilel Status Bleck, White, etc. Yes 21 No 1 Never Merried 2 Married Black 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorcad Yeer or Detes: 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede.completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Masonary Private Industry 12 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) LeRoy Scales, Jr. Ella Thomas 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Sharon Scales/Wife 6926 Aquamarine CT 20743 CApital Heights, MD 20b. Plece of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, cremetory or other place) 1 Burial 2 Cremation 3 Removal from Stete Forest Hills Cemetery 4 Donetion 5 Other (Specify) 3/4/2000 Clinton, MD 22. Name end Address of Fecility te of Funeral Servica Lin Tyrone J. Young Funeral Services 719 Kennedy Street, NW Wash., DC 20011 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, abock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Death Immediate Ceuse (Final ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Ceuse (Disease or Injury thet initieled events resulting in deeth) Last Due to (or es e consequenca of): Due to (or as e consequença of) Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 | Yes 2 | No 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 No 28c. Injury at Work? 27. Manner of Deeth 28e. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation Natural 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

must be notified at

7 is marked other than "natural", or items traumatic event, the Medical Examiner ma

Director

Funeral

by

Completed

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filed within 72 hours after

Hygiene.

. Pages 1 and 2 should be fill ment of Health and Mental Hant: If them 27 is marked oth jury or other traumatic even with and Mental F. 7 is mark-

permit. Page Department of Important: If any Injury or

Baltimore, Maryland 21215-0020

/Medical

the burial-tran and certificate be axec USB as ō signed by the a need page 2 has Attending Physician:

Records, P.O. Box 68760.

Division of Vital

Examiner Physician/Medical þ Completed certificate director Be P this funeral Certification: After 24 hours after death. Funeral Director: After

To the Hospital within 24 hours a To the Funeral Completely filled

State Registra

edical

Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated.

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number

Certifying Phyaician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed or 23a) (Type, Print) MARIO F. GOLLE

6 Could not be determined

3001

HOSPITAL DRIVE, CHEVER

281. Location (Street end Number or Rural Route Number, City or Town, Stete)

MAR 0 2 2000

2 Accident

3 Suicide

29a. Certifier

29b. Signeture

4 Homicide

(Check only one)

31. Date filed (Month, Day, Yeer)

32. Registrar's Signature

Caralle de Company de la compa * and the second second The total of the test to melancing the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** February 25, 2000 Charles H Smith 1:55 PM /Medical 4a. Facility Nama (If not institution, giva street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** National Lutheran Home Rockville Montgomery 8. Date of Birth (Month, Dev. Ye If Under 24 Hrs. 5. Social Security Number If Undar 1 Year 7. Aga (In yrs. last birthday) Birthpleca (Steta or Foreign Country) **Funeral** , 1908 Months Days Hours 1 M 2□ F 191-03-6211 Vrs 91 **Director** OHIO Usual Residence of Decedent with tha Manyland Stete MD County MONTGOMERY 10c. City. Town or Location 10d. inside City Limits 28a-f show traumatic event, the Medical Examiner inset be notified at CHEVY CHASE Director 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 4615- DeRUSSEY PARKWAY 20815 238 USA Completed by Funeral tems 12. Was Decadent Ever in U.S. Armed Forcas? 11. Maritai Status 13. Was Decadent of Hispanic Orlgin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - American Indian, Bieck, Whita, atc. filed within 72 hours aftar 1 Navar Married 2 Married 1 ☐ Yes 2 ☐XNo if Yas, Give Yeer or Dates: 21215-0020 6 1 Yes 2 No Specify: Specify: WHITE 3 XWidowed 4 □ Divorcad "natural", 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usuel Occupation (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Baltimore, Maryland 21215
Demit. Pages 1 and 2 should be filed within 72
Beharmant of Haalth and Mantal Hygiana.
Important: If item 27 is marked other than "na any injury or other traumatic event, the Media once. Elementery/Secondery (0-12) College (1-4or 5+) STORE OWNER APPLIANCE-FURNITURE 9 17. Father's Nama (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumeme) Be HARRIS WILLIAM SMITH ELIZABETH A. TAYLOR To 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MRS. LOIS JONES-DAUGHTER 4615- DeRUSSEY PKWY., CHEVY CHASE, MD. 20815 20a. Method of Disposition 20b. Placa of Disposition (Neme of cematery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 XCramation 3 ☐ Ramoval from State METROPOLITAN CREMATORY-2/29 ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servica Licensee 22. Name and Address of Fecility HYSONG CO., INC. s that caused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, Approximete Intervei Between Onset and Death **Physician** /Medical Immediate Cause (Final nonelle disease or condition resulting in death) neumonia Examiner Due to (or es a consequenca of) neces The law requires that the death cartificate be axecuted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Ceuse (Disease or injury that initieted avents resulting in deeth) Last and Division of Vital Records, P.O. Box 68760, attanding physician for usa as the buria crisse Physician/Medicai Dua to (or as a consequence of): Pert fi. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ata has been signed by page 2 should be datach 212 No 3 Probably & Unknown 1 Yes à 24b. Were autopsy findings available prior to complation of causa of deeth? Be Completed 24a. Wes en eutopsy performed? certificata 20 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: "
within 24 hours after death."

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Piece of Deeth (Check only one) 200 No Othar: 4 Nursing Homa 5 ☐ Rasidenca 6 ☐ Othar (Specify) 20 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28e. Date of injury (Month, Dey Year) Certification: 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident 1 ☐ Yas 2 ☐ No investigation In by the 6 Could not be determined 3 Sulcida 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Steta) 4 Homloide within 24 hours aft to the Funeral Di complataly filled In Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and pleca, end due to the ceuse(s) end menner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) and menner stated. 29b. Signature and title of cen-29c. License number 29d. Dete signed (Month, Day, Year) 30. Neme and eddrass of person who completed cause of deeth (item 23e) (Type, Print)

State Registrar

MAR 0 1 2000

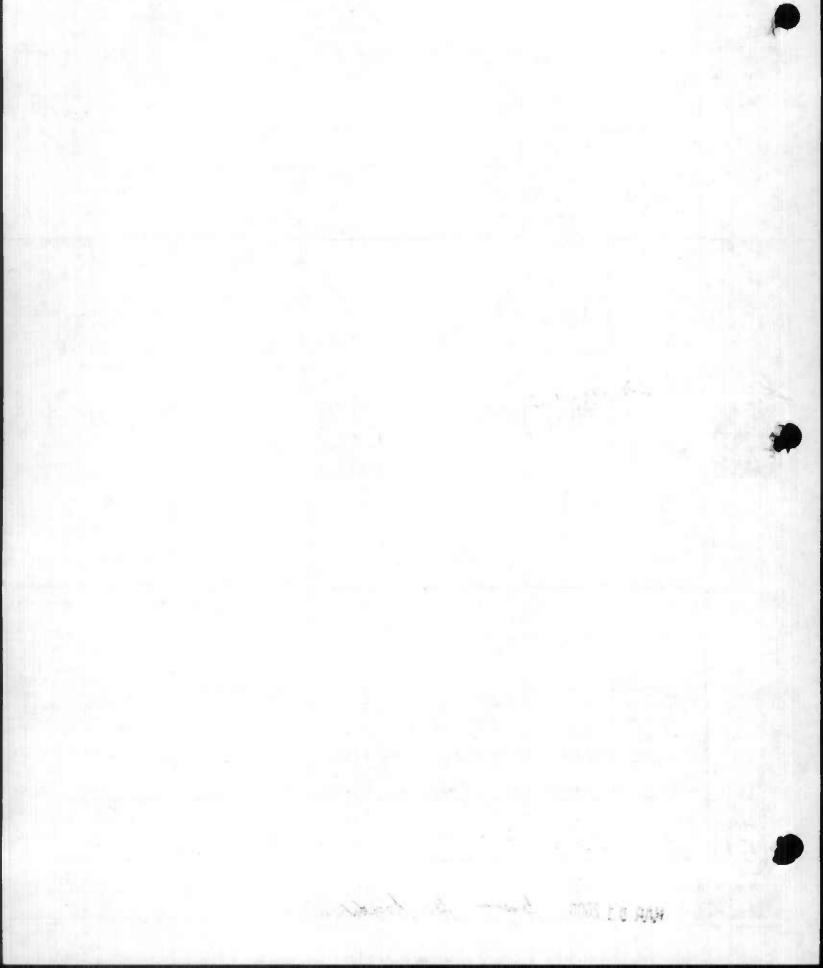
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32. Registrar's Signeture

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20850



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician
/Medical
Examiner

Director

by Funeral

Completed

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Funerai Director

the Maryland 28a-f show must be notified at with 8 items 23a death 6 "natural",

21215-0020

Maryland

Baltimore,

the Medical Examiner

filed within 72 hours after permit. Peges 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any Injury or other traumatic event, it is Media.

Physician /Medicai Examiner

The law requires that the death certificate be executed physician been signed by the should be deteched page 2 certificate or Attanding Physician: this funeral After t death. Director: / effer To the Hospital o within 24 hours eff To the Funeral Di completely filled in

py

Be Completed

To

Medical Certification:

Records, P.O. Box 68760,

Division of Vital

Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Daath 3. Time of Death Month Day Philip E. Shayne March 1, 2000 9:00pm 4a. Facility Nama (If not institution, giva street and numbar) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Nursing Center Montgomery Rockville 7. Aga (In yrs. last birthday) If Undar 1 Yaar | Months Days 5. Social Sacurity Number Birthplaca (Stata or Foreign Country) PEM 20F 225-28-6927 Usual Rasidance of Decedant 10a, Stata 10b. County 10c. City, Town or Location 10d. insida City Limits Maryland Montgomery Bethesda 1 Yas 2 No 10e. Street and Numbar 10f. Zip Coda 10g. Citizan of What Country? 5225 Pooks Hill Rd. 20814 United States 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedant of Hispanic OrlgIn? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarloan Indian, Bleck, Whita, atc. 1 ☐ Yas 2 ☐ No If Yes, Giva Yaar or Dates: WWII 1 Navar Marriad Married 1 Vas 2√2 No Specify: 3 ☐ Widowad 4 ☐ Divorced Specify: White 15. Dacadant's Educetion (Specify only highast grada completed) Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa retired) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) College (1-4or 5+) Business Broker Private 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Edward Shayne Rose Kronman 19a. Informant's Name/Raiationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Joel Kawer/ Son in Law 409 Suffield Dr. Gaithersburg, MD. 20878 20a. Method of Disposition 20b. Piaca of Disposition (Nama of cematary, cramatory or other place) Data 20c. Location - City or Town, State 1X Burial 2 ☐ Cramation 3 ☐ Ramovai from Stata King David Memorial Falls Church, VA. 4 Donation 5 Othar (Specify) 3/5 21. Signatura of Europea Service Licer 22. Nama and Addrass of Facility Takoma Funeral Home. 254 Carroll St. NW. Washington. DC.20012 Part L Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, index, or hard feilure. List only one cause on each line. Immadiata Causa (Final SARDIAC Hours diseesa or condition rasulting in death) YEARS ARTERY Sequentially list conditions, if any, leading to Immadiata causa. Enter Undarlying Cause (Disease or injury that initiated evants rasulting In death) Last Dua to (or as a consequence of): DIAGETES 10 YEARS Dua to (or as a consaquance of):

Physician/Medical

Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I.

PROSTATE

LYMPHATIC

LOUKENIA

26. Place of Deeth (Check only one)

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Were autopsy findings available prior to complation of causa of death?

1 Yas 200 No

1 Yas 2 No

25. Was casa refarred to madical 1 Yas 2 No

27. Mennar of Death 1 Naturel 5 Panding invastigation

28a. Dete of injury (Month, Day Year)

1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of

28a. Place of Injury - At homa, farm, streat, factory, offica building, atc. (Specify)

28c. Injury at Work? 1 ☐ Yas 2 ☐ No

Othar: 4 Nursing Home 5 Rasidanca 6 Othar (Specify) 28d. Dascribe how Injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

29a. Certifian

2 Accident

3 Suicida

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the causa(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and mannar stated.

29b. Signature and titla of certifiar Marti

- 07,0

29c. Licansa number

29d. Data signed (Month, Day, Year) Trancet 2

30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print)

GRA1= TARTIN 15225 Shady Grove Rd. Rockville, MD. 20850

31. Data filed (Month, Day, Year)

MAR 0 3 2000

6 ☐ Could not be datarmined

32. Registrar's Signature

State

Registrar

1. 24 0 3 1800 Commercial St. 1 1800

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Dey J. **Physician** March 1, Jacqueline Stecker 2000 8:30AM /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street and number) 4c. County of Deeth Examiner 5711 Joan Lane Temple Hills Prince George's | Hunder 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth (Month, Dey, Year) | 9. Birthplece (State of Birth (Month, Dey, Year) | Jan. 30,1930 | North Carolina 7. Age (In yrs. lest birthdey) 5 Social Security Number **Funeral** Months 1□M 2⊠F Yrs. 231-28-3171 70 Director Usual Residence of Decedent the Marylend 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show 1 Yes 2 No Directo Maryland Prince George's Temple Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Peges 1 and 2 should be filed within 72 hours efter death with tent of Health and Mental Hygiene.

nt: if fem 27 is marked other than "natural", or items 23a or in yor other traumals event, the Medical Examine man by or other traumals event, the Medical Examine man to a U.S.A. 5711 Joan Lane 20748 Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ŽŽ No If Yes, Give Yeer or Dates: 13. Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Merital Stetus Bleck, White, etc. 1 Never Married XXMerried 3altimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: White Š 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cotlege (1-4or 5+) N/A Elementery/Secondery (0-12) 12th Homemaker Home 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Charles Roland Gaylord Myrtle Elena 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) Donald M. Stecker (Husband) 5711 Joan Lane Temple Hills, Maryland 20748 20b. Place of Disposition (Neme of cemetery, cremetery or other place) March 6, 2000 20c. Location - City or Town, Stete 20e. Method of Disposition XXBuriel 2 Cremetion 3 Removel from State Depertment of Important: If any injury or Maryland State Veterans Cem. Cheltenham, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Lee Funeral Home, Inc. 21. Signeture of Funerel Service Licensee 6633 Old Alexandria Ferry Road Clinton, MD 20735 23a. Pert1. Enter the disease, or complications that caused the path. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical Cancer Examiner Due to (or es a consequence of): Examiner physician end the burial-transit that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury that initieted events resulting in death) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of): 80 980 23b. Did tobacco use contribute to the cause of death? ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 ☐ Unknown signed t by 24b. Were autopsy findings aveilable prior to completion of causa of deeth? 24a. Wes en eutopsy Completed certificate hes b director, page 2 s 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Wes cese referred to medicel examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 9 Residence 6 Other (Specify) 1 Yes 2 No 10 1 ☐ Inpatient 2 ☐ ER/Outpetlent 3 ☐ DOA funeral 27. Manger of Deeth 28d. Describe how injury occurred Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 1 Neturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident efter deetl Director: 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 4 Homlcide 2 24 hours Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end place, and due to the cause(s) and menner as stated.

| Certifying Physician: To the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hosp othin 24 ho To the Fund completely f

Registrar

31. Dete filed (Month, Dey, Year) MAR 0 3 2000

30. Neme and eddress of person who come

29b. Signature end title of certified

Harvey I. Katzen M.D. 8926 Woodyard Road #201 Clinton, Maryland 20735-4218 32 Registrer's Signeture

d cause of deeth (Item 23e) (Type, Print)

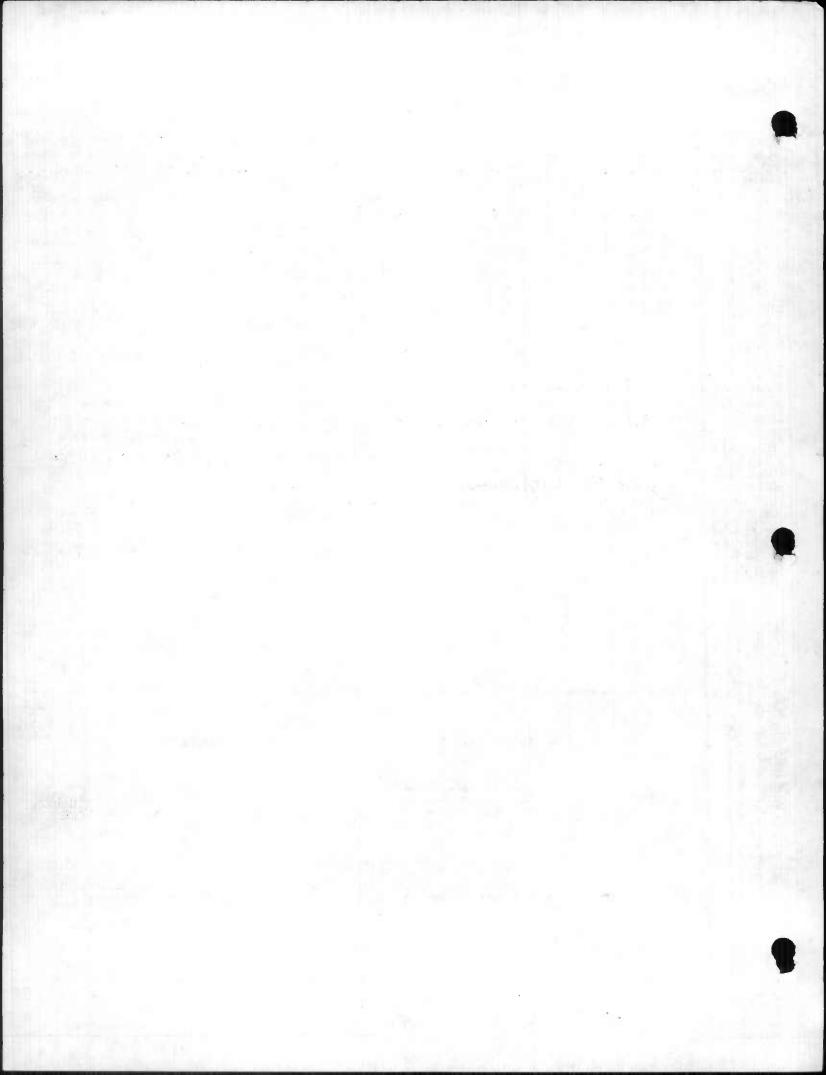
29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

					ate of Death	, ,	eg. No. 00	08802.
	Physician	Decedent's Neme (First, Middle, La.				2. Dete of Dea Month	_	3. Time of Death
150	/Medical	DAPHENE As Facility Name (If not institution as		TIPPETT	4b. City, Town, or I	March		
	Examiner	4e Facility Neme (If not institution, given 9216 Overlook Tra					4c. County of De	
1	uneral	5. Social Security Number 6. S	Sex . 7. Age (In yrs.		Ft. Washinder 1 Yeer Munder 24 Hrs.	8. Dete of Birth	Prince G	irthplace (State or Foreign
Di	irector	220-26-6542 Usuel Residence of Decedent	□M 21ŽIF 81	Yrs. Mont	hs Days Hours Min.	8. Dete of Birth (Month, Day Aug. 20	,1918 V	irginia
with the Maryland	show stati	10a. Stete 10b. County	George's	ty, Town or Location Accoked	o k			10d. Inside City Limits
P W	be notified Director	7.0.3	deorge 3					1 ☐ Yes 2 No
th with t	0 20	15746 Livingst	on Road	101.	Zip Code 20607		Og. Citizen of What C	Country?
d 21215-0020 flied within 72 hours after death hygiene.	Feminer must Examiner must by Funeral	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1Yes _ CIV No If Yes, Give Year or Dates:		scedent of Hispanic Origin? (S specify Cuban, Mexican, Puerl s 2 No Specify:	pecify Yes or No- Pican, etc.)	14. Race - Arr Bleck, Wh Specify:	
21215-0020 d within 72 hours at piene.	nt, tre Medical tr. Completed	15. Decedent's Ed (Specify only highest grant Elemantary/Secondary (0-12)		16a. Decedent's L (Give kind of life. DO NO	Jsuel Occupation work done during most of wor Tuse retired)	king	16b. Kind of Busines	s/Industry
d 212 filed withi	other the	AT FORM AND		Statist			J. S. Gove	rnment
Maryland d2 should be file th and Mental Hy	2 0	17. Fether's Neme (First, Middle, Last, William M. Sn				. Kerns	Maiden Sumeme)	
and Me		19a. tntorment's Name Reletionship (19b. Mailing Add	rass (Street and Number or Ru		, City or Town, State,	Zip Code)
6 70		William H. Tippe		d 15746 L	ivingston Road	, Accoke	ek, Maryla	and 20607
Baltimore,	If item 2 or other	20a. Method of Disposition 1 W Burial 2 Compution 3 C	20b. I	Place of Disposition (cemetery, crematory	Name of or other piece)	Date	20c. Location - City of	r Town, Stata
timent	# 7	4 Ocnation 5 Other (Specif	n or		orial Gardens			, Maryland
Balti Permit. Departm	mew in any in	MARK G. BROH	ropaulu	The	e Huntt Funera O. Box 156, W	1 Home,	Inc. Maryland	20604
		23a. Pert . Enter the disease, or com shock, or heart teilure. List only	plications thet caused the deal one cause on each line.	th. Do not enter tha r	mode of dying, such es cardiec	or respiretory err	est,	Approximata tntarval Between Onset and Deeth
	sician edical	Immediate Cause (Finel	DEC	TAL (ARCINON	A		G STARC
	miner	diseese or condition resulting In death)	8.			~(71400
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68760, ificate be axecu		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	c					
X 687	0 0	resulting In death) Last	Due to (c	of):				
Box death cert	atten I for u	Charles Others also Manual and Malana		h'		ant mide		
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Records,	rate has been signed by the attending page 2 should be detached for use as Completed by Physician/Me					24a. Was e perfor		. Were eutopsy tindings available prior to completion of cause of death?
	page 2					1 □ Y	es 2 De No	1 ☐ Yes 2 ☐ No
/ita	ctor.	25. Was case reterred to medical examiner?			26. Place of Dea	th (Check only or	ne)	Daughters
0 4	P P	1 ☐ Yes 2 No 27. Manner of Death	Hospitet: 1 Inpatient 2				ence 6 Other (Sp	Home
D Bull	After the funeral tion:	1 Natural 5 Pending 2 Accident Investigation	28a. Date of thjury (Month, Day Year)	28b. Time of tnjury	28c. tnjury at Work? 1 Yes 2 No	200. Describe in	ow injury occurred	
Division or Attending after death.	al Director: After ti led in by the funera Certification:	3 Suicide 6 Could not b	28e. Place of Injury - At h	ome, term, street, tec		28t. Location (S	reet and Number or I	Rural Route Number,
Di o les	ed in	4 🗆 Fromicae	building, etc. (Specil	9/		City or Town	1, 3(6(6)	
Hospital	To the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one)	ysician: To the best of my kno niner: On the basis of examina and manner steted.	wledge, death occur ation and/or investigat	red at the time, date and place tion, in my opinion, deeth occu	, and due to the c rred at tha time, d	ause(s) end manner ate and plece, end de	as stated. ue to tha cause(s)
To the within 2	To the comp	29b. Signetura and title of certifier	0		29c. License number	2	9d. Date signed (Mor	
		Kymple M	P		D43346		3/3/2	000
		30 Neme and address of person who	completed cause of death (Iter	1 4 .	en enan #	78/ /	21 (NIDN	un 20735
	Ctoto	31. Date filed (Month, Day, Year)	32. Registrar's Signa	WOOJ PA	NO SUND.	201	20170.017	0000 00.00
	State Registrar	MAR 0.6.2	non Semen	14	land,			

DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene

				Cei	rtificate of	Death		Reg. No.	0	00003			
		1. Decedent's Neme (First, Middle, La	st)				2. Dete of D		Vaar	3. Time of Deeth			
Physic		SANDRA LANETTE	THOMAS				Month Februar	Day cy 25, 20	Yaar	07:30 AM			
/Med Exam		4a Facility Nema (If not institution, giv	e street end number)			4b. City, Town,	or Location of Dea						
Funera Directo	1	578-88-9633		s. lest birthday) Yrs.	if Under 1 Year Months Days		Hrs. 8. Date of Bi (Month, D	Prince Pr	9. Birthpla Counti	rges ace (State or Foreign ny) sh. D.C.			
5 of		Usuel Residence of Decedent 10e. Stata t 0b. County	100.0	ity. Town or Lo	veation				10	Od. Inside City Limits			
e Maryla la-f ahov	ctor	Maryland Prince		andover					10	1√Xes 2□No			
th with th	ai Director	10e. Street and Number 4018 Warner Aven	ue Apt. # A7		t Of. Zip Coda 2078	34	1	10g. Citizen of V USA	Vhet Count	ry?			
Maryland 21215-0020 d 2 should be filled within 72 hours after death with the Maryland th and Mental Hygiene. 71 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examiner must be inclined at	by Funeral	11. Manitel Status t Nevar Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:		Wes Decedant of It Yes, specify Cul		? (Specify Yas or Nuerto Rican, etc.)	14. Rece - American Indian, Black, White, etc. Specify: Black		etc.			
5-0 72 hc	Completed	15. Decedent's E	ducation	16e. Dece	dent's Usuel Occu	pation during most of	working	16b. Kind of Bu	siness/Inde	ustry			
within eng.	npie	Eiementery/Secondery (0-12)	College (t-4or 5+)	life.	kind of work done DO NOT use retir	9d)							
Maryland 212: d 2 should be filed within th and Mental Hygiena. 7 le merked other then traumatic event, the M	Co	12		Cas	hier	Total most on			t Food	ds			
be filled tal Hygid d other	Be	17. Father's Neme (First, Middle, Last					Name (First, Middle		Θ)				
arylan should be ind Mental merked o	2	David L. Marr					a Raspber						
2 sho and and and and		t 9e. informent's Name/Relationship (or Rurel Route Num						
C (4 F		Richard E. Tho				Avenue		T		MD 20784			
Dear 40 40 D		20e. Method of Disposition *CABurial 2 □ Cramation 3 □ 4 □ Donetion 5 □ Other (Specia	Removel from State	cemetary, cres	osition (Neme of metory or other pl		Dete 1. 2-29-00	20c. Location	1				
Haltimo		22. Nome and Address of Facility Strickland Funeral Sec 6500 Allentown Rd, Camp Springs, MD 2											
Physiclar	_	23a. Partt. Enter the diseasa, or com shock, or heart failure. List only	one cause on each line.							Approximete Intervel Between Onset and Death			
/Medica Examine	_	Immediate Ceuse (Finel diseese or condition resulting in death)	. Arout Re			राष्ट्रका	JynoRo	me	1				
	je 📕	Due to (or es e consequence of): b. HVMAN IMMUND DEFICIENCY SYNDROME											
executed n and ial-transit	Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Undertying Couse (Dissess or injury) that idiated example.											
OX 68/60, certificate be executed ding physician and use as the burial-transit	Medicai	Ceuse (Diseese or injury that initiated events resulting in deeth) Lest	C	(or as e conseq	quanca of):								
death death	sician	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause givan in Pert I.						23b. Did tobacco use contribute to the cause					
	y Phy						1	Yes 2 No	3 Prob	ably 4 Unknown			
requestion should	Completed by Physician/							s en eutopsy formed?	con	ere eutopsy findings nileble prior to inpletion of causa deeth?			
r Vital Ke ysicien: The lav is certificate has director, page 2	NO.						1	Yas 2 No	10	Yes 2□ No			
in i	Be (25. Was case referred to medical exeminer?				26. Plece of	Deeth (Check only	one)					
OT VITA Physician: this certific ral director,	To	1 Yes 2 No	Hospitel: 1 Inpatient 2	☐ ER/Outpetier	nt 3 DOA	ther: 4 Nursi	ng Home 5□ Res	sidence 6 Oth	er (Specify)			
DIVISION O To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completaly filled in by the funeral	Certification:	27. Menner of Deeth Naturel 5 Pending investigatio	28a. Dete of Injury (Month, Dey Year)	28b. Time o Injury	W	uryet ork? ⊒Yes 2∐No		how Injury occur	red				
DIVISION If or Attending I safter death. I Director: After d in by the fune	ertific	3 Suicida 6 Could not b		reat, fectory, office			(Street and Numb own, Stete)	er or Rural	Route Number,				
To the Hospital within 24 hours To the Funerel completaly filled	edicai C		ysician: To the best of my kr niner: On the basis of examin and mannar steted.										
Within 2 To the	Me									Dey, Year)			
F S F S		1/11A	n		DA	0421	0/07	2/25	7200	0			
(5)		30. Nama end address of person who	completed cause of deeth (It	em 23a) (Type,	Print)	MA	10787	,					
9	tate	31. Dete filed (Month, Day, Xear)	32. Registrer's Sig	neture	1	(100)	N 7 0)						
Regis		FEB 2 9 2000	pegua	D. A	porke								

FEB 2.9 MGA

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FREDDIE LOUIS THRNER 02 20 2000 1:48 AM 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth 665 STRETFORD WAY, #104 LANDOVER PRINCE GEORGE'S If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Days Months Hours 41 426-15-0920 June 4, 1958 Mississippi Usual Residence of Decedent 10h. Counts 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Maryland Prince George's Landover 10e Street and Number 10f. Zio Code 10g, Citizen of What Country? 665 Stretford Way, #104 20785 U.S.A. 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Amped Forces? 1 △ Yes 2 ☐ No 14. Rece - American Indien, Biack, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: **Black** If Yes, Give Year or Detes: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 4½ yrs Elementary/Secondary (0-12) Disbursing Clerk Government 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Commadore Turner Estella Floyd 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jane Turner/Wife 665 Stretford Way, #104, Landover, Maryland 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 03/01 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete Liberty Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2000 Kossuth, Mississippi 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility
J.B. JENKINS FUNERAL HOME 7474 Landover Road, Landover, Maryland 20785 ie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Pert1. Enter the disea shock, or heart failure. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) RENAL CELL CARCINOMA METASTATIC Commothe Due to (or es a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy lindings eveilable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

physician and the burial-transit

2 signed b

certificate

Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica staty filled in by the funeral director, I

To the Hospital of Wiltin 24 hours at To the Funeral D completely filled

The law requires that the death certificate be executed

Box 68760

P.O. 1

Records.

of Vital

Division

Examiner

Physician/Medical

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Completed

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Certification: To

Medical

Physician

/Medical

Examiner

Funeral

Director

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"natural", or items 23s or

Hygiena.

parmit. Pages 1 and 2 should be file.
Department of Heath and Mental Hy important: if Nem 27 is marked other any Injury or other transcreed other.

72 hours after

Baltimore, Maryland 21215-0020

Directo

Funeral

P

Completed

Be

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 21 No

26. Place of Death (Check only one)

25. Was case referred to medicat examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending

1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, State) Place of Injury - At home, farm, street, lectory, office building, etc. (Specify) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

29b. Signeture and title of certifie

29c. License number

29d. Dete signed (Month, Dey, Year)

MD-058430-4 FEB, 23, 2000 FEUN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (ARL R. WILLIS, WP, WALTER REED AME

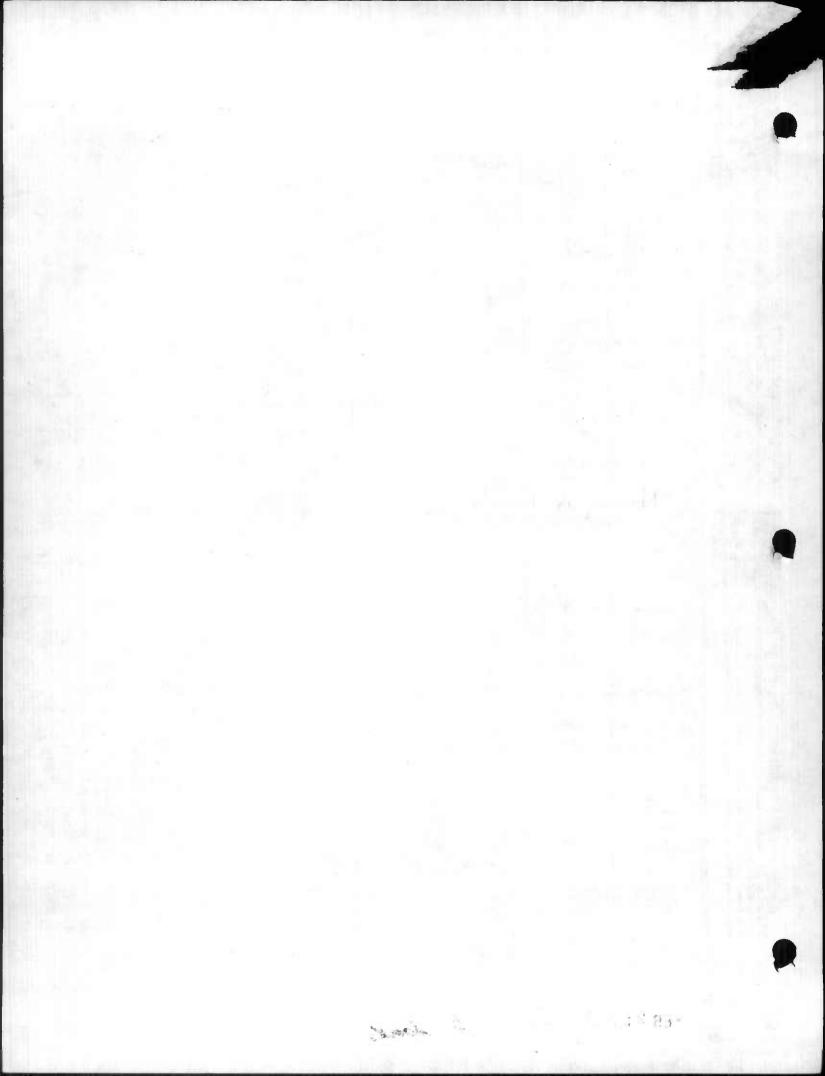
6900 GEORGIA AVE, WARD 78, HEMELING SERVICE
31. Date filed (Month, Day, Year)
32. Registrar's Signeture WAHINGTON, DC 20207 31. Date filed (Month, Day, Year)

State Registrar

FEB 2 5 2000



ports



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BLANCA TALBERT February 2000 2:55AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death spital 7. Age (In yrs. last birthdey) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) | Nov. 21, 1914 Prince George's Hospital Prince George's 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1□ M 2□F 127-26-1121 Cuba Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐,Yes 2 ☐ No Maryland | Prince George's Mt. Rainier 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4304 Kaywood Dr. #3 20712 Cuba 12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 No Specify: Specify: Hispanic 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 6th Housekeeper Private 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Luciano Villegas Blanca Martinez 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcela E. Talbert - Daughter 4304 Kaywood Dr., #3; Mt. Rainier, MD 20712 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Quantico National Cem. 3/1/2000 Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility Stewart Funeral Home 2) elevar 4001 Benning Rd., N.E. Wash., D.C. Part I Error the disease, or complications that claused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, above, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated ments. rial fibrillation Due to (or as a consequence of): renal failure Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? Coronary Astery 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown mellitus, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? Peripheral voiscular diseare Cerebro vascular accident 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Hospitaf: 1 Inpetient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 2 No

20052848

28c. Injury et Work?

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

Landover Hills

29c. License number

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

Box 68760,

P.O. I

of Vital Records.

Physician

/Medical

Examiner

Directo

Funeral

Director

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Battimore, Maryland 21215-0020 (plemit. Pages 1 and 2 should be filed within 72 hours afti because it important of health and Mental hygiene. Important if them 27 is marked other than "natural, or I any injury or other traumatic event, the Medical Examination.

Physician/Medical Examiner Certification: To Be ours after death. nerel Director: After this villed in by the funeral di

or Attending Physician: Division To the Hospital of within 24 hours at To the Funeral Discontinuity filled

DHMH 16 Rev 6/95

State Registrar

FEB 2 8 2000

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1 Yes 2 No

5 Pending investigation

6 ☐ Could not be

27. Manner of Death

1 ENatural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

74th Avenue

Nancy Kalpana Timothy

28a. Date of Injury (Month, Day Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANCY K. DIMOTKLY

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 16 Ray 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death isam Month Day Year Mary Elizabeth 4chruary 2,000 29 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Air. HOME 295ant VIEW Musing arroll 8. Date of Birth (Month, Day, Yea Ian. 20, If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Ye Birthplace (State or Foreign Country) Year) Deys Hours 1□M 2⊠F Months Maryland 218-32-1767 91 1909 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Carrol1 New Windsor Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21776 U.S.A. 1117 Slingluff Lane 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Meritel Stetus Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 1 ☐ Yes 2 2 No Specify: Black. 3 ☑ Widowed 4 ☐ Divorced 15. Decedent'e Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) domestic private homes 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Edward Jackson Laura Milberry 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Darlene Toop/ granddaughter 1117 Slingluff Lane New Windsor, MD 21776 20a. Method of Disposition 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stete Dete Mt. Olive Cemetery 1 Durial 2 Cremetion 3 Removal from Stete 3/4/00 Oak Orchard, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service License 22. Name end Address of Fecility Hartzler Funeral Home en 310 Church St. New Windsor, MD 21776 23a. Part. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart tailure. List only one ceuse on each line. Approximate Interval Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) Myocardial Infarction One Day Due to (or es a consequence ot) Hypertension Years Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as e consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notified at

"natural", or items 23a or

parmit. Pages 1 and 2 should be filed within 72 hours after Ospariment of Health and Mertal Hygianu. Proportant: If Item 27 is marked other than "natural", or its ny filem 27 is marked other than "natural", or its ny fillury or other thanmark award, the Medical Examina

Baltimore, Maryland 21215-0020

Director

Funeral

by

Completed

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Examiner Physician/Medical be del þ Completed certificate funeral director, Be Certification: To After this 24 hours after death. • Funeral Director: A completaly filled in by

or Attending Physician: The law requires that the death certificate be executed

Hospital

within 2 To the \$

Division of Vitai Records, P.O. Box 68760.

	d				
Pert II. Other eignificant conditions of	ontributing to death but not re-	sulting in the underlying o	cause given in Pert I.		ontribute to the cause of death?
Senile Demer	tia			1 ☐ Yes 2 ☑ No	3 Probably 4 Unknown
Osteoarthrit	is			24a. Wes an eutopsy performed?	24b. Were eutopsy findings available prior to completion of cause of death?
				1 ☐ Yes 2 🕅 No	1 ☐ Yes 2€ No
25. Wes case reterred to medical examiner?			26. Place of De	eeth (Check only one)	
1 ☐ Yes 2 ☒ No	Hospitel: 1 ☐ Inpatient 2 ☐	☐ ER/Outpatient 3☐ DO	OA Other: 4 Dinursing	Home 5 ☐ Residence 6 ☐ O	ther (Specify)
27. Manner of Death 1 Natural 2 Accident 5 Pending Investigation		28b. Time of Injury M	28c. Injury at Work? 1 Yes 2 No	28d. Describe how injury occu	urred
3 Suicide 6 Could not b 4 Homicide determined	28e. Plece of thiury - At h building, etc. (Speci	nome, ferm, street, fector	y, office	28f. Location (Street and Nun City or Town, State)	nber or Rural Route Number,
				e, and due to the cause(s) end n curred at the time, date and place	

State Registrar

edical

N B Vellanki, MD; 9055, Chevrolet Drive; #100, Ellicott City, MD 21042

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Dete filed (Month, Dey, Year) MAR 0 2 2000

29b. Signature and title ot certities



29c. License number

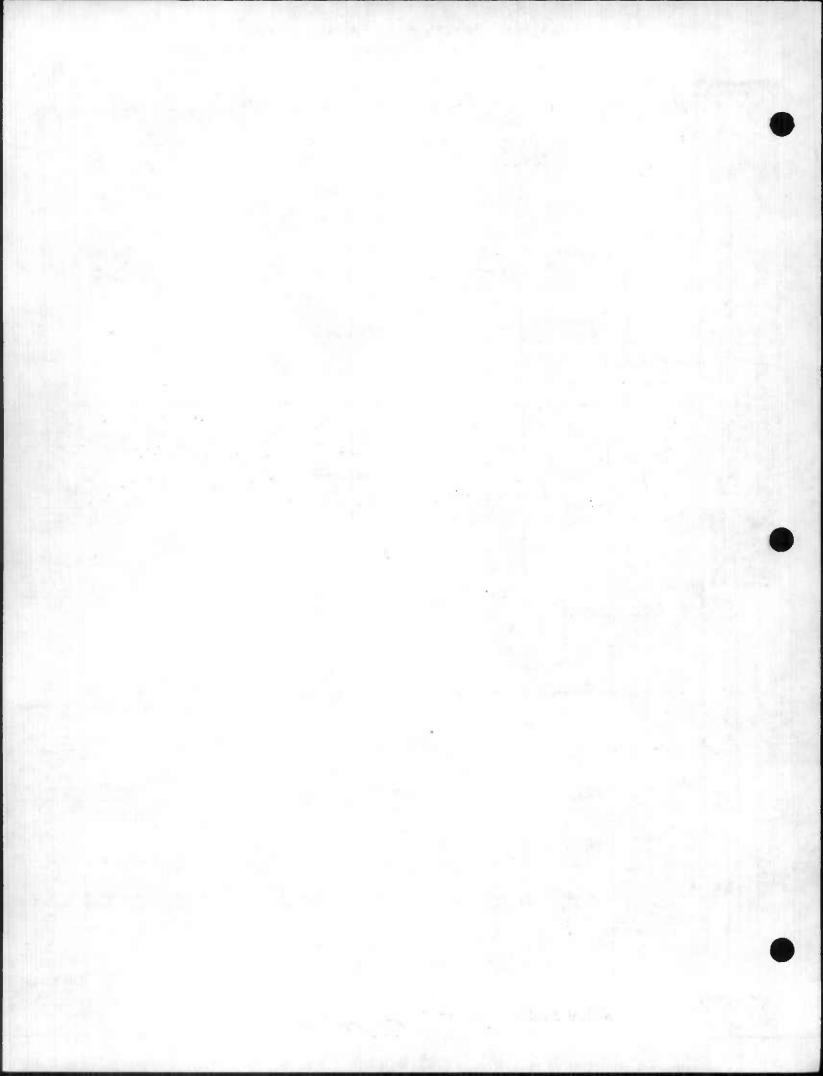
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29d. Date signed (Month, Day, Year)

February

29

2000

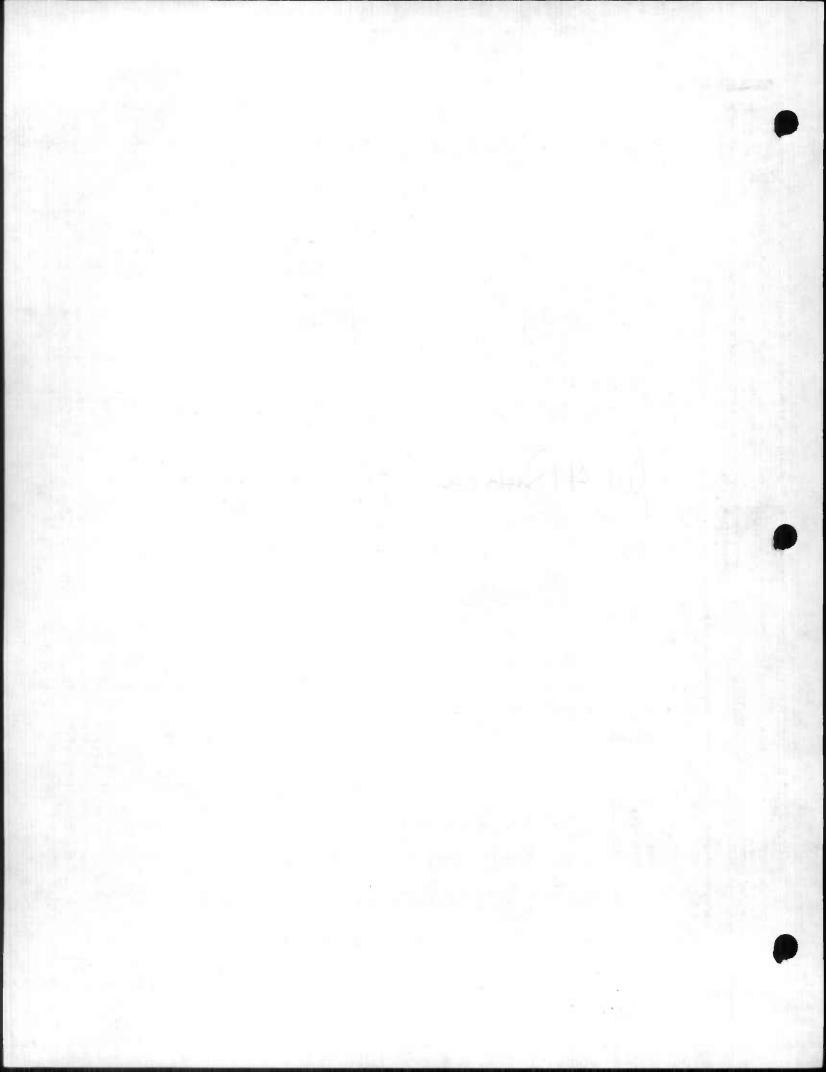


	t's Name (First,	Middle, Last)			00	ertifica	ale UI	Deam	2. Date of D		V	3. Time of Death
n al	Samuel	G. Vi	to						Februa		000	9:00 A.M.
	Name (If not ins	itution, give s	treet and nu	ımber)				4b. City, Town, or Rockv11:	r Location of Des Le	Montg	ty of Death Omery	
5. Social Se 578-2	curity Number 0-1106	Λ	M 2□ F	7. Age (In y	rs. last birthda 5 Yrs.	y) If Uno Month	der 1 Year as Days	If Under 24 Hi Hours Mi	8. Date of B Month, D Februa			place (State or Foreign ASHINGTON,
Usual Resid 10a. State	lence of Decade 10b. C			10c.	City, Town or	Location						10d. Inside City Limits
Maryla	nd Pri	nce Ge	orges	Nev	w Carro	11to	n					1 Yes 2 No
	Sprague	Place					Zip Code 784			10g. Citizen o		ntry?
11. Marital		1	2. Wes Dec Amed F	2 No		B. Wes Dec If Yes, s		dispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or Norto Rican, etc.)	lo- 14. Ri	ace - Ameri ack, White,	etc.
3 □ Wid	lowed 4 Div	orced redent's Educ	Year or [ive Dates: 194:		edent's U	Λ			16b. Kind of	Whi	
Elementa	(Specify only in ry/Secondary (0	nighest grade	completed) (1-4or 5+)	(Gir	mber	work done use retire	during most of w d)	rorking	Plumbi		ldusity
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	ant's Name/Rel								Rural Route Num Carroll			
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21. Signam	of Funeral Se	rvice License	a	elmel					t. Linco Rd. Bren			
	Cause (Final condition	, or comple List only on a			eath. Do not e			ng, such as card	ac or respiratory	arrest,	3	Approximete Intervel Between Onset and Death years
			Me		ic Pros			ncer			1	year
Sequential	y list conditions, ng to immediate er Underlying	1 b			(or as a cons							
that initiate	Base of Injury	{		Due to	(or as a cons	equence o	():					
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27. Manner	of Death ural 5 P	ending vestigation	26a. Date		28b. Time	of	28c. Inju		*	how injury occ		ny nospiec
3 ☐ Sui 4 ☐ Ho	d	ould not be etermined	28e, Place build	e of Injury - Al ling, etc. (Spe	t home, ferm, socify)	street, fect	ory, office			(Street and Nur own, State)	nber or Rur	ral Route Number,
29a. Certific (Check one)	only 2 Me	tifying Physi Sical Examin	er: On the b	e best of my k pasis of exami oner steted.	nowledge, dei ination and/or	ath occurre investigati	ed et the ti on, in my	me, date and pla opinion, death oc	ce, and due to the curred at the time	e cause(s) and r	menner as : e, and due (stated. to the cause(s)
29b. Signat	ore and atte of o	orities M	1	10	1		29c. Licen 3599	se number		29d. Date sign ebruary		
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CERSING COMPANY

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death eb. Year WALSH **Physician** JOSEPHINE 2000 4c County of Death /Medical 48 Facility Name/(If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner 9. Birthplace (State Country)
Maine If Under 24 Hrs. 8. Data of Birth (Month, Day, Year)
Dec. 12,1910 7. Age (In yrs. last birthdey 1□M 2XF **Funeral** Months Days 89 107-01-1490 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. Stata 10c. City, Town or Location 10d. Insida City Limits r than "natural", or items 23s or 28s-f show the Mexical Examiner count be notified at Maryland Charles Waldorf 1 Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code 20602 2642 Ulster Court U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yas, Giva Year or Dates: 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: Completed by 3 NWidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry al Hyglene. Elementary/Secondary (0-12) College (1-4or 5+) 11 Seamstress Clothing Manufacture other traumatic event, Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if flem 27 is marked orbh any Injury or other traumatic event page. 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be Sophia Sieko Michael Flis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 2642 Ulster Court, Waldorf, Maryland 20602 Sandra A. Rizzo/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition 1 X Buria 2 Crem tion 3 Removal from State 4 Dona Holy Trinity Cemetery 03-06-2000 Utica, New York 5 0 21. Signatur 22. Name and Address of Facility The Huntt Funeral Home, Inc. M00053 P.O. Box 156, Waldorf, Maryland mew G. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical ACUTE RUMONARY Immediata Cause (Final EDEMA disease or condition rasulting in death) Examiner INFANCILLA Examiner MYOCAMORIL To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the tuneral director, page 2 should be detached for use as the burlat-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): ATHEROS CLEROSI) Box 68760, Physician/Medical Dua to (or as a consequence of): DIABETE MELLENI. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records. P.O. 1 Yes 2 No 3 Probably 4 Unknown HYPENTENSLOW þ CHRONIC RENAL INSVIPRICIENCY 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? COPD 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was case referred to medical examiner? Be 25. Place of Death (Check only one) 1 Yes aPINo Other: 4□ Nursing Home 5□ Residence 6 □Other (Specify) Certification: To 1 ☐ Inpetient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of tnjury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending invastigation 1 ANatural 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D37467 3-1-2000 85 High Street Ste # 5 worldeng MD 20602 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signatura 31. Data filed (Month, Day, Year) State MAR 0 6 2000 Registrar



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middla, Last) February 37, 2000 John Eldon Welch 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Prince Georges Doctors Community Hospital Lanham Hours Min. June 22, 1914 Washington, DC If Undar 1 Yaar 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthplace (Stata or Foreign Days 1₩ 2□F Months 577-01-8769 85 Usual Rasidance of Decedant 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yas 2 No Prince Georges New Carrollton Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6123 Lamont Drive 20784 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☑ No If Yas, Giva Race - American Indian, Black, Whita, atc. 11 Marital Status 1 ☐ Nevar Married 2 ☐ Married Specify: White 1 Yas 2 No Specify: 3 Nidowed 4 Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Plumber Construction 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) John Welch Mabel Hurley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Jay L. Welch/ Son 1503 H Berkley Ct. Harwood, MD 20776 20b. Plece of Disposition (Nema of cematery, crematory or other piece) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1XXBurial 2 Cramation 3 Ramoval from Stata March 1,2000 Brentwood, MD Lincoln Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Addrass of Facility Ft. Lincoln Funeral Home Signatura of Funerel Service Licenses 3401 Bladensburg Rd. Brentwood, MD 20722 erlocal 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Intarval Between Onset and Death Acute Respiratory Failure Immediata Causa (Final disaasa or condition rasulting in death) Dua to (or as a consequence of): Sever Enphysema Due to (or as a consequence of): Sequentially list conditions, if any, leading to Immadiata ceusa. Enter Undarlying Cause (Disease or injury that initiated avants rasulting in death) Last Congestive Heart Failure 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed?

Physician /Medical Examiner

bermit. Pages 1 and 2 should be file.
Bepartment of Health and Mental Hy important: If Item 27 is marked other any Injury or other traumatic event

Physician

/Medical

Examiner

10a. Stata

Funeral

Director

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filed within 72 hours after

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Baltimore, Maryland

Director

Funeral

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Examiner Physician/Medical ate hes been signed by the page 2 should be detach P Be Completed certificate Medical Certification: To this funeral After death. To the Hospital or Attendition within 24 hours after death or the Funeral Director: A completely filled in by the fi

The law requires that the deeth certificate be executed

or Attending Physician:

Box 68760.

P.O.

of Vital Records.

Division

Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 24b. Ware eutopsy findings available prior to completion of cause of death? 1 Yas 28 No 1 ☐ Yas 2 ☐ No 25. Was cesa refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No 1 € Impatient 2 □ ER/Outpatient 3 □ DOA 27. Mannar of Death 28e. Data of Injury (Month, Dey Year) 28b. Time of 28d. Dascribe how Injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No Invastigetion 2 Accidant 6 ☐ Could not be datarmined 3 ☐ Suicida 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 29a. Cartifiar (Check only one) 1 Certifying Phyeician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and mannar stated. 29b. Signatura and titla of certifiar 29c. Licensa number 29d. Data signed (Month, Day, Year)

D26287

State Registrar

MBERARD 31. Data filed (Month, Day, Year)

Baltimore 305 32. Registrar's Signatura

Are 107 College Park mis 20740

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30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 8,2000 5 -ers beren Epruse /Medical 4e Facility Neme (If not institution give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mary Im Baltimore hedica If Under 24 Hrs. If Under 1 Year 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1□M 2□F 223 82 2759 46 19, Director Jan. 1954 North Carolina Usuel Residence of Decedent with the Maryland 10a State 10b County 10c. City, Town or Location ahow 10d. Inside City Limits r than "natural", or Nerns 23s or 28s-f show the Medical Examiner must be notified at 1 Nes 2 No Director Virginia Stafford Fredericksburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 60 Lady Jane Lane 22406 United States Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indien, Bleck, White, etc. 11. Meritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 ☐ Yes 2 ∑No If Yes, Give Yeer or Detes: 1 Never Merried 20 Merried Baltimore, Maryland 21215-0020 1 Yes 2√No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life: DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry I Hygiena. Elementery/Secondery (0-12) Coilege (1-4or 5+) Technician Automotive 12 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fit ment of Health and Mental Hant: If Itam 27 is marked off jury or other traumatic even Be Elzberry Waters, Jr. Jacqueline Morgan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 60 Lady Jane Lane Fredericksburg Virginia 22406 Rita S. Waters Wife 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition 2000 cemetery, crematory or other place) March 2, 1 ☐ Buriei 2 ☐ Cremetion 3 ☐ Removei from Stete permit. Page Department of Important: If any Injury or 4 Donation 5 Dother (Specify) Entombment Lakemont Memorial Gardens Davidsonville Maryland 22 Name and Address of Facility Robert E. Evans Funeral Home, Inc. 21. Signature of Funerel Service Licensee ovon 16000 Annapolis Rd. Bowie Maryland 20715 23a. Pet1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician /Medical Immediete Cause (Finai OSIS diseese or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner oginous the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as e consequence of): The law requires that the death certificate be execu P.O. Box 68760. Physician/Medical Due to (or es a consequence of): for usa as Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No sate has been signed by page 2 should be detact Records, by 24b. Were autopsy findings evailable prior to completion of cause of deeth? Be Completed 24a. Was an autopsy SKI NO 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Impatient Certification: To 2 ER/Outpatient 3 DOA this funeral 27. Menper of Deetl 28d. Describe how injury occurred 28b. Time of 28e. Dete of Injury (Month, Day Year) 28c. Injury at Work? After 1 Netural 5 Pending investigation after death. 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Hospital DEscertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 | Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. edical 29e. Certifier pletaly (Check only one) To the To the To the 29b. Signeture end title of certifie 29c. License number 29d. Date signed (Month, Dev. Year) 30. Name and eddress of person who completed ceuse of death (Item 23a) (Type, Print) S. Greene Seffre St Macy land 31. Dete filed (Month, Dey, Year) 3. Registrer's Signeture State MAR 0 1 2000 Registrar

DHMH 16 Rev 6/95

State of Maryland / Departme

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ate of Death	Reg. No.	00			U	-	V	

CAROLYN RICH WARD CAROLYN RICH						Cei	rtificat	e of L	Death		F	leg. No.		00	01
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Noma and address of person with completed cause of deeth (Horn 23a) (Type, Print) Peburah Sherri Man 9901 Medical Center Dr. Rockville mp	25. \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\ \\	Menner of Death Menner of Death Matural Calcident Suicide Check only Che	investigetic 6 Could not be determined Descripting Pt Medical Examined	hysician: To the miner: On the band mar	best of my kn asis of exemin nar stated.	owledge, deetletion end/or in	vestigation	c. License	number	th occurred	at the time, o	dete end place 29d. Dete sig	ce, and due	to the cau	er)

DHMH 16 Ray 6/95

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death M 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month DEPRUARY Day Year **Physician** WARREN WOOTEN 27,2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth **Examiner** PRINCE GEORGES CHEVERLY PRINCE GEORGES HOSPITAL CENTER 8. Date of Birth Month, Day, Year) NOV . 05, 1 7. Age (In yrs. last birthdav) 9. Birthpiace (State or Foreign 5. Social Security Numl 244-12-2712 **Funeral** Months Days Hours 100 M 20 F 78 NORTH CAROLIN Director Usual Residence of Decedent the Merylend r 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MARYLAND PRINCE GEORGES FT. WASHINGTON Y Yes 2□ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours efter death with Inant of Health end Mentel Hygiena.

Int: If item 27 is marked other than "naturel", or items 23a or inry or other traumetic event, the Medical Examines must be in 6208 JOE KLUTSCH DRIVE 20744 UNITED STATES Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? XXXVes 2 ☐ No If Yes, Give Year or Detes: 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes X No Specify: Specific RO-AMERICAN þ 3XXWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH Coilege (1-4or 5+) N/A DISABLED 18 Mother's Name (First Middle Maiden Sumame) 17. Fether's Name (First, Middle, Last) WILLIAM C. . WOOTEN CARRIE WOOTEN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) YVONNE GLOVER/DAUGHTER 6208 JOE KLUTSCH DR., FT. WASHINGTON, MD 20744 20b. Placa of Disposition (Neme of cemetery, cremetory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 X Burial 2 Cremation 3 Remove from Sta permit. Page Department of Important: If any injury or once. MARYLAND VETERANS CEM. MAR. 06, 2000 CHELTENHAM, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Fundal Service Lizena 22 Name and Address of Fecility DUDLEY FUNERAL HOME 3200 RHODE ISLAND AVE., MT. RAINIER, MD 20712 EDWARD M. AMDLEY 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) ARTERIOSCLEROTIC CARPIOVASCULAR PISEASE Examiner Due to (or as e consequence of) Examiner physician and the buriel-transit Sequentially list condillons, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequenca of): ettending ph Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown SCAIZOPHRENIA Division of Vital Records. à 24b. Were autopsy findings evallable prior to 24a. Was an autopsy Completed completion of cause s certificate hes t 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Deeth 28d. Describe how injury occurred 28b. Time of 28e. Date of Injury (Month, Day Year) 28c. Injury at Work? After 1 Neturel 2 Accident 5 Pending aftar death. 1 Yes 2 No investigation 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide n 24 hou. 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. To the Hospi within 24 hou To the Funer complately fil 29e. Certifier edical 29b. Signature 29d. Date signed (Month, Dey, Year) 29c. License number 28,2000 d cause of death (item 23a) (Type, Print) Va MARIO F. GOLLE PRIVE, CHEVERLY

3001

Registrer's Signeture

State Registrar 31. Date filed (Month, Day, Year)

MAR 0 2 2000

DHMH 16 Rev 6/95

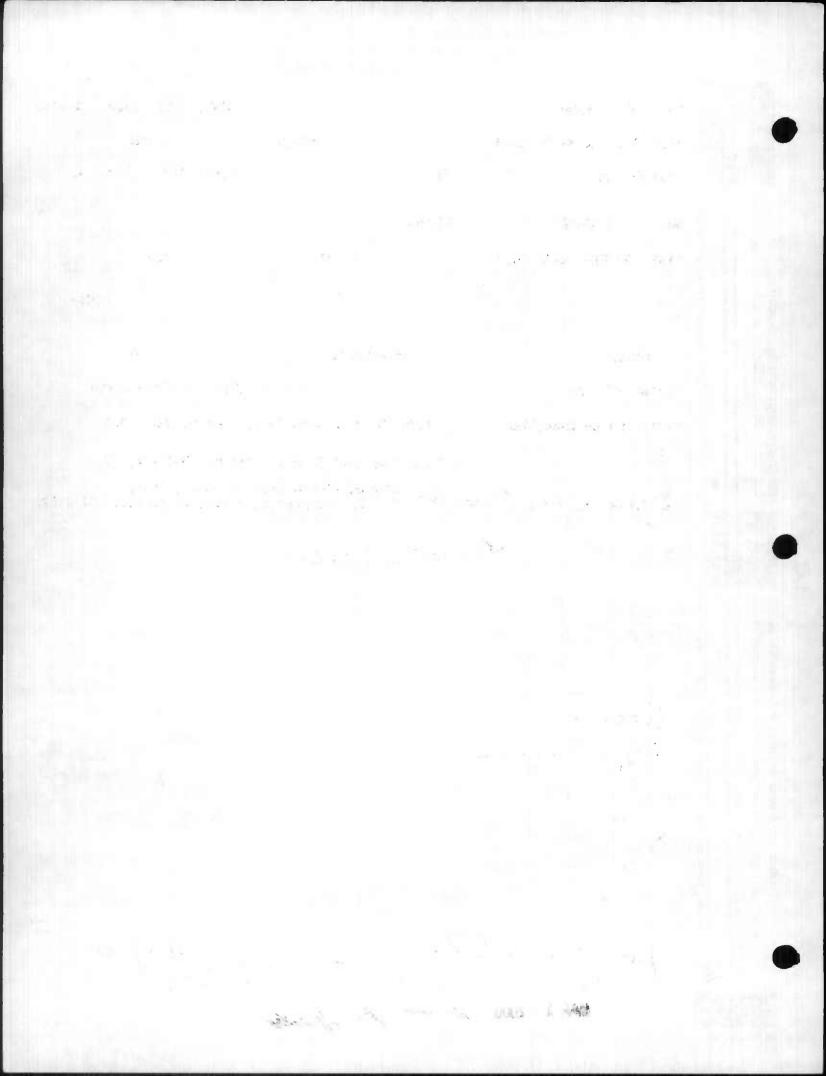
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State of Maryland / Dep	artment of Health	and Ment	al Hygiene
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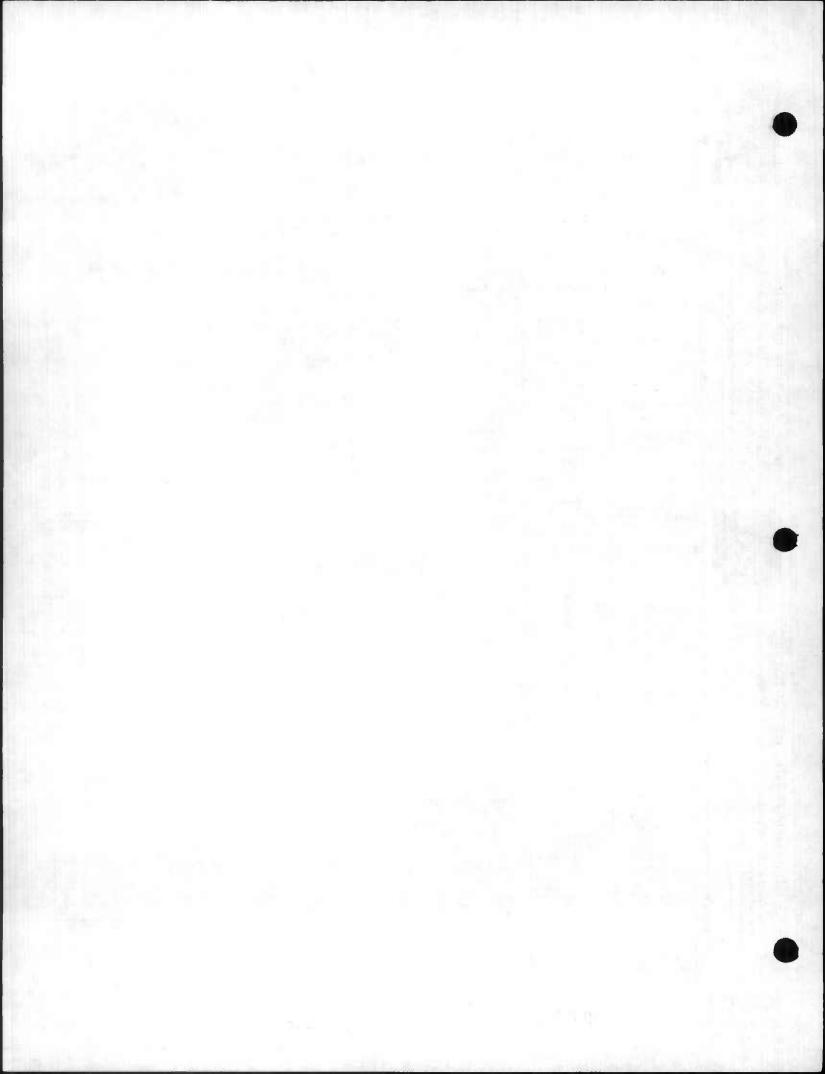
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Physician Medical Examiner Sadie Ann Walls Sadie Ann Wa						Cei	rtificate	e of	Death	- 1	Reg. No.	00	0001
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Figure 1998 And 1999		Sadie Ann	Walls										9:45am
Scientific Security Processing Control Contr				street and numi	ber)				4b. City, Town, or	Location of Death	4c. Count	ty of Death	
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The specific form of the speci	the rect		Cecii		LIF	CLOTT	10f. Zip	Code			10g. Citizen of	What Cour	ntry?
The specific form of the speci	3a o	1102 Old E	lk Nock	Road			2	1921			IISA		
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William Anders Section Section	elf, or its Example by Full			1 Yes 2	No No					to Pican, etc.)			
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Sequentially ist conditions. Sequen	Be doth	17. Father's Name (First	, Middla, Last)					-					
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Betty Tales Daughter Date Daughter Date	l 2 sh end c is r												Code)
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123 S. Washington, Havre de Grace, MD 21078 238. First Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval Batween Oriental and Death of the Control of	I he is			emoval from SI		ametery, cres	netory or of	ther ple	ce)	Date	200. Location	- City of 10	Wit, State
123 S. Washington, Havre de Grace, MD 21078 23a Fart Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, inclination of the state o	. Pe imen lury	4 Donation 5 D	Other (Specify)		Bel					3/2/00	Bel Ai	r, MiD	
23s. Ray Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardier or respiratory arrest, Approximate Sease, or the heart feature. List only one cause on each line.	Depa Impo eny li pncs	21. Signatura of Funeral	Service License	5.5	Kin	_ M	itchel	I-Si	mith Fun				WD 21078
Physicial mediate Cause (Final desemble) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.		23a. Further the dis	seese, or complication	cations that cer	used the death	n. Do not ent	er the mode	e of dyi	ng, such es cardie	c or respiratory a	rrest,		Approximate
The selling in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Sequentially list conditions, and any, leading to immediate Cause (Disease or Injury that initiated events rasuling in death) Last Due to (or as a consequence of): Due to (or as a conse	Physician	July of Hourt fair	uro. List only on	o cause on ea			0						Onset and Death
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322 E. Coul AVE North East MD 21901		Julie	- rolu	done	\times 1	ND		~	1000)	0/28	100)
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State of Maryland / Department of Health and Mental Hygiene

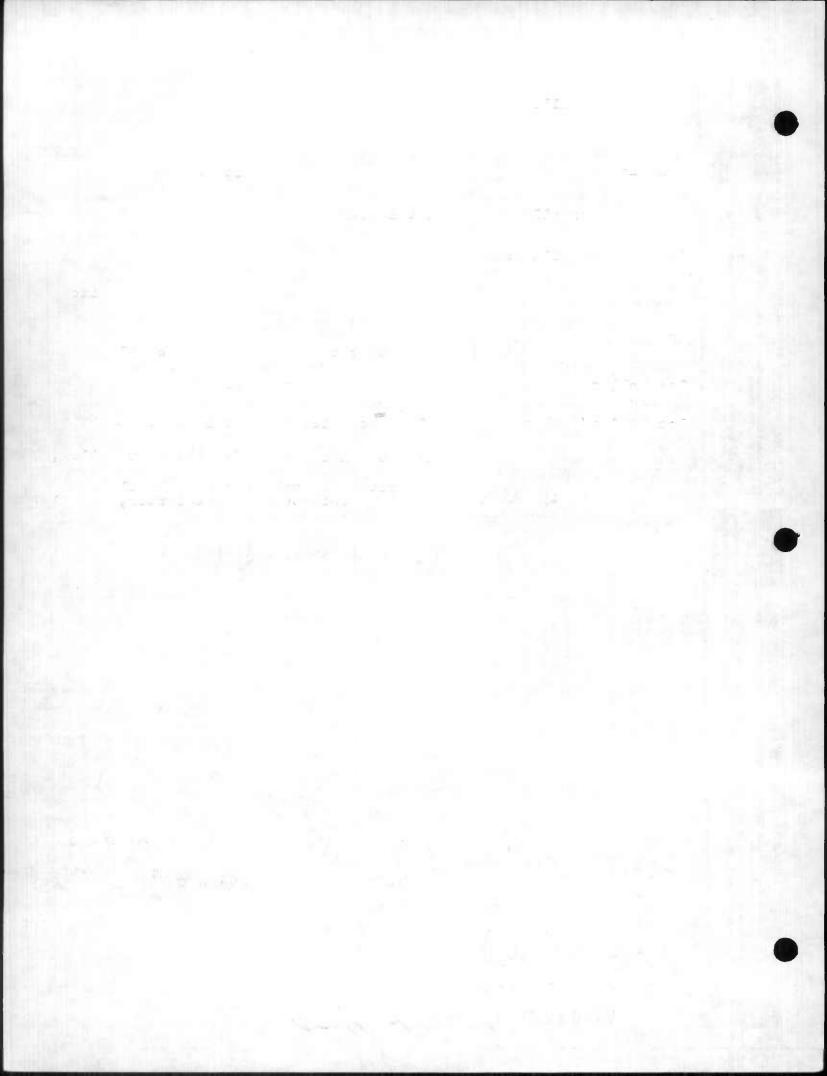
				Certifica	te of	Death		Reg	J. No.		000	010
	1. Decedent's Name (First, Middle, L	ast)					2. Date Mon	of Death	Day	Vaar	3. Time	of Death
Physicia /Medic	UPICIA LAVA	da Welch					Marc			2000	12	120 p.
Examin	An Carilla Alama Mana Lanthatan -	ive street and number)				4b. City, Town	, or Location o	Death	4c. County	of Deeth		
r di	Carroll Count	y General Ho	spital			Westmi	nster		Car	roll		
Funeral Director	5. Social Security Number 6. 220-28-8707		n <i>yrs. last birtl</i> 85 Y	Month:	er 1 Year Days		Hrs. 8. Date Min. Jul	of Birth oth, Day, Y	1914	9. Birthpl Count West	Vir	te or Foreign ginia
у	Usual Residence of Decedent											
aryta dan dan	10a. State 10b. County		Dc. City, Town							10		City Limits
N Page	Maryland Carre	011		Union		ge					1 KU Y	es 2 No
	Maryland Carro	St.		10f. Z	ip Code	21791		100). Citizen of \	What Coun	try?	
Maryland 21215-0020 d 2 should be filed within 72 hours after dest in and Mental Hygiene. 7 is meriked other then "netural", or items it fraumetic event, the Medical Examiner mu	11. Marital Status 1 Never Merried 2 A Married 3 Widowed 4 Divorced	12. Wes Decedent Eve Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:	or in U,S.	13. Wes Dec			n? (Specify Yes Puerto Rican, e	or No-		e - America ck, White, o	etc.	•
2 5 E	15. Decedent's E	ducation	16a. I	Decedent's Us	uel Occu	pation		16	Sb. Kind of Bu	usiness/Ind	lustry	
27 m 2 m	15. Decedent's E (Specify only highest gr Elementery/Secondary (0-12)	rade completed) College (1-4or 5+)		Give kind of w life. DO NOT	vork done use retire	during most o	t working					
N D M	5	55.15g5 (1 45.151)		seams	tress	3			cloth	ing f	acto	ory
D STATE	17. Father's Name (First, Middle, Las	t)				18. Mother's	Name (First, I	Middle, Ma	iden Suman	10)		
/ all	Melvin Lovejoy					Mat	ilda Wa	lker				
and when the same	19a. Informant's Name/Relationship	(Type, Print)	19b.	Meiling Addre	ss (Stree	and Number	or Rural Route	Number, (City or Town,	Stete, Zip	Code)	
	Mahlon N. Welch/	husband	11	2 W. L	ocust	St.	Union	Brid	ge, MD	2179	1	
Sattimore, emit. Pages 1 a Appartment of Her my injury or othe BGS.	20a. Method of Disposition 1 \(\tilde{\Omega} \) Buriel 2 \(\tilde{\Omega} \) Cremation 3 \(\tilde{\Omega} \) 4 \(\tilde{\Omega} \) Donetion 5 \(\tilde{\Omega} \) Other (Spec	Removal from State		Disposition (No crematory or	other pla		3/5/0		oc. Location -			
Baltill permit. P Departmi importan any injur	21. Signatura of Funeral Service Lice		5000	22. Name	end Addre	ess of Fecility	Hartzle	er Fu	neral	Home		
40240	23e. Pert1. Enter the disease, or cor shock, or heart feiture. List only	W. Xxxxx	gen			adway			dge, M	ID 217	791	
/Medical Examiner	Immediate Ceuse (Final disease or condition resulting in deeth)	b. UR	osep:	STS		proba	ible p	nei	<u>kmon</u>	10	3 0	lays
E 50	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	o to (or as a co									
death cert the attending thed for use	<u>e</u>											
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v requires been sign should be	Completed by						248	. Was an performe		ava	ere autopa ailable pric mpletion o death?	sy findings or to of cause
ysician: The lav ysician: The lav griector, page 2	E							1 🗆 Yes	215 No	10	Yes 2	2□ No
n: no. tifica	25. Was case reterred to medical					26. Place of	f Death (Check	only one				
Physician: r this certific mal director,	axaminer?	Hospitel: 1 Hopatient	2 ER/Outr	patient 3 [ON ON	hor-	ing Home 5		ce 6 □Oth	er (Specifi	v)	
Physical distribution	27. Manner of Death	28a. Date of Injury (Month, Day Ye		me ot	28c. Inju Wo				injury occur			
To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral	27. Manner of Death 1	28e. Place of Injury	- At home, farr	M n, street, facto	1□	Yes 2 No	28f. Loca		et and Numb	er or Rura	l Route N	lumber,
ours after or filled in	29a, Certifier 12 Certifying P	building, etc. (4		death coourse	d at the ti	me date and		or Town,		oner ee et	eted	
To the Hospital within 24 hours a To the Funeral completely filled	(Check only 2 Medical Exa	miner: On the basis of example and manner stated	aminetion and/									e(s)
o the omb	29b. Signature and title of certifier			2	9c. Licens	se number		290	I. Date signe	d (Month, i	Day, Year	7)
- 3 - 3	Disa Kjir	- , m, D.			D 5	241	9	1	March	, 2,	20	00
	30. Name and address of person who West minster 31. Date filed (Month Day Year)	MD 2-115h	(Item 23a) (T	Carro	ISA K	County	P. Gent	00 11 eral	Hos	ial :tal	Ave	Nue,
Stat	e on boto mod (month, bo), rodiy	32. Registrar's	Signature	1.	,	1			7			



State of Maryland / Department of Health and Mental Hygiene 00 08817

			Certificate of	Death	Reg	j. No.	00011
Dhysisian	1. Decedent's Name (First, Middle, Las	()			2. Date of Death Month	Day Year	3. Time of Death
Physician /Medical	Chad Lee Wel				MARCH.	2, 2000	0005 AM
Examiner	4a Facility Name (If not institution, give UNIVERSITY HOSP:			4b. City, Town, or Lo BALT IMORE		4c. County of Deat	th
Funeral Director	5. Social Security Number 6. S 216-88-1373	MIN OFF	ast birthday) If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birt 1963	Inplace (State or Foreign buntry) KS
yland	10a. State 10b. County	10c. City	, Town or Location	-			10d. Inside City Limits
vith the Man	MD Carro	ll W	estminster		100	Citizen of Milest Co.	1 ☐ Yes 2 ☑ No
23s or set be or	3922 Arters Mi	ll Road	211	58	109	g. Citizen of What Co USA	ountry r
21215-0020 d within 72 hours after death with the Maryland blens. Pr than "natural", or items 23s or 28s-f show than "natural", or items 23s or 28s-f show than "natural", branches must be notified at Completed by Funeral Director	11. Marital Status P_Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,s Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates;	S. 13. Was Decedent of If Yes, specify Cul	Hispanic Origin? (Spe ban, Mexican, Puerto I Specify:	city Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
I 21215-002 ed within 72 hours yglene. wer then "neturel", it, the Medical and Completed by	15. Decedent's Ed (Specify only highest grad	ucation de completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retin	ipation e during most of worki	ng 16	6b. Kind of Business/	Industry
within within the war	Elementary/Secondary (0-12)	College (1-4or 5+)	Student	ed)		School	
nd 2	17. Father's Name (First, Middle, Last)	4+1	brudent	18. Mother's Name	(First, Middle, Ma		
ylanc ould be fi Mentel I- arked out afte ever	Lee Weller			Mary S	teinber	g	
a spen	19a. Informant's Name/Relationship (7	ype, Print)	19b. Mailing Address (Stree	et and Number or Rura	l Route Number, C	City or Town, State, a	Zip Code)
1 end 2 Health a em 27 le other tree	Lee Weller/Fat:	her	1825 Bened	ict Rd W	estmins	ter, MD	21157
Baltimore, N permit. Pages 1 and Department of Health Important: If item 27 any injury or other u page.	20a. Method of Disposition 1 12 Burial 2 Cremetion 3 4 Donation 5 Other (Specify	Removel from State	ace of Disposition (Name of emetery, crematory or other pla easant Vall			easant V	
Balt permit. Depart Import any inj ang	21. Signature of Funeral Service Licen	Tel .	22. Name and Addr Pritts F 412 Wash	uneral Ho	ome and	Chapel	MD 21157
BOX 68760, seth cartificate be executed to transfer as the buriel-fransit for use as the buriel-fransit claryMedical Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	bDue to (or	es a consequence of): as a consequence of):	junes of	f Hea	i-d	Onset and Death
P.O. het the de datached datached Physic	Part II. Other significant conditions co	ntributing to death but not resu	iting in the underlying cause g	iven in Pert I.	23b. Did tobe	-	lo the cause of death?
40 2 W CL					24a. Was an a performe	d?	Were autopsy findings available prior to completion of cause of death?
Con Page					Arres	2 □ No	Yes 2□ No
VIta	25. Was case referred to medical examiner?	Hospital:	la	26. Place of Deeth	(Check only one)		
Physic physic and direction of T.	1 No 2 No 2 No 27. Manner of Death	28s. Date of Injury	Proutpatient 3CI DON		ne 5 Residence 28d. Describe how	ce 6 Other (Spe	eify)
DIVISION Of VITAI or Attending Physicien: To she death. Director: After this cartification; to be certification; To Be C	1 Natural 5 Pending investigation	Month, Day Pear)	1918 M	ury at ork? Ves 2 □ No	Subject	I bea	ten
Division of Vital Re to the Hospital or Attending Physicien: The is within 24 hours after death. To the Funeral Director: After this cartificate he completely filled in by the funeral director; page. Medical Certification: To Be Comp	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hor building, etc. (Specify,	me, farm, street, factory, office		28f. Location (Streetly or Town,	et and Number or Ri State) 2 Alley	Westminte
e Hospil n 24 hours e Funer bistely fills	29a. Cartifying Phy 22 Medical Exam	sician: To the best of my know iner: On the basis of examinati and manner stated.	riedge, death occurred at the to and/or investigation, in my	time, date end place, a opinion, deeth occurre	and due to the caused et the time, date	se(s) end manne as and place, and due	s stated. e to the cause(s)
To the within To the comp	29b. Signature and title of certifier	an		C.M.E	29d	1. Date signed (Mont MARCH 2	
(JULARON LOCK	ompleted cause of death (Item	23a) (Type, Print) 11 Penn Street	, Baltimor	e, Maryl	and 21201	
State Registrar	MAR 0 3 2	32. Registrar's Signate					

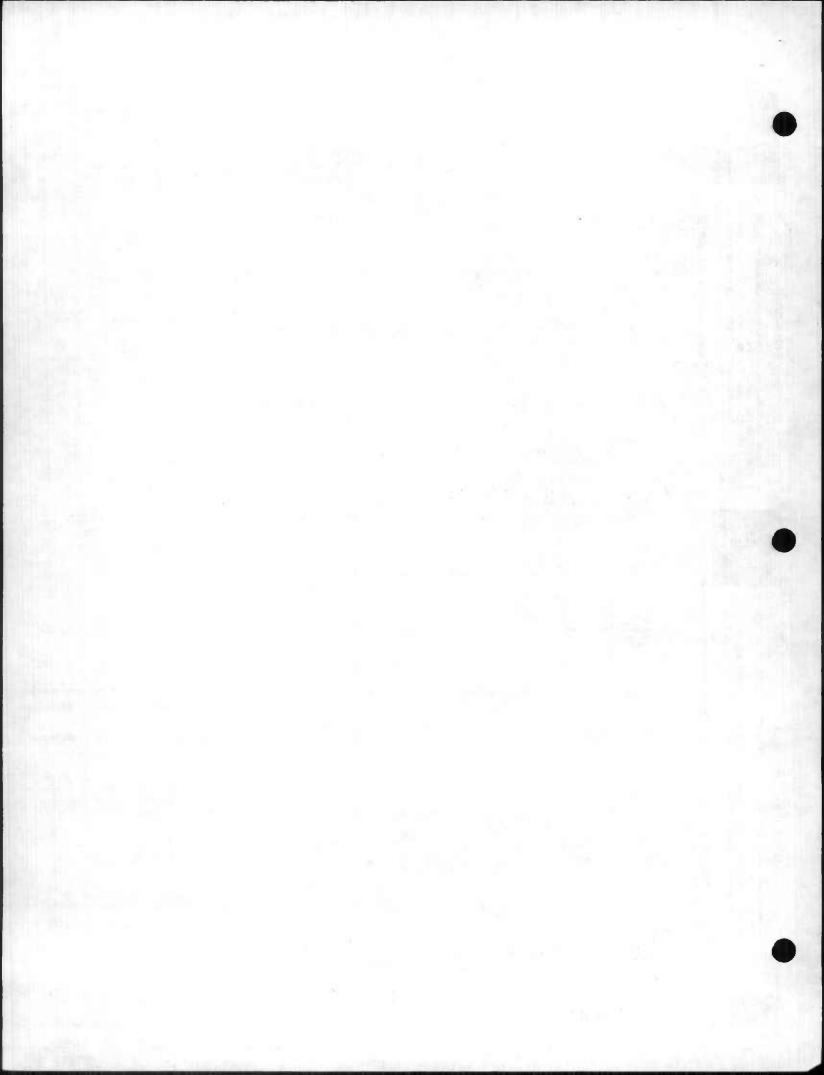
DHMH 16 Rev 6/95



00-1115-021 Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Justin Scott Warne State of Maryland / Department of Health and Mental Hygiene
JVW AMEND ITEMS: #23 PART I, 27, 28 -F PER MED C781 3-16-2000 WR.
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Scott Justin Warner February 26,2000 8:45A.M /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Libertytown
| Hunder 24 Hrs. | 8. Date Frederick Route 26 at Dance Hall Road If Under 1 Ya 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Apr. 3, 1980 9. Birthplace (State or Foreign Country) Maryland **Funeral** Days Hours Months 18 M 2□ F 19 214-13-7051 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location t 0d. toside City Limits 1 Yes 2 No New Windsor Maryland Frederick Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 re 23a or U.S.A. 14830 Toll Rd. 21776 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien 11. Meritat Stetus Bleck, White, etc. 72 hours after 1 Never Merried 2 ☐ Merried 8 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hypiene. Wer then Elementery/Secondary (0-12) College (1-4or 5+) roofer construction Saltimore, Maryland 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental H tant: If them 27 is marked off jury or other traumatic even Be Rodney Steven Warner Anne Cooley 19e. tnforment's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anne Cooley Burger/ mother 14830 Toll Rd. New Windsor, MD 21776 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, Stete 1 Buriat 2 □ Cremetion 3 □ Removet from Stete 3/1/00 Libertytown, MD 4 ☐ Donetion 5 ☐ Other (Specify) Peter's Cemetery 22. Name and Address of Facility
Hartzler Funeral Home 21. Signature of Furgerel Service License 11802 Liberty Rd. Libertytown, MD 21762 23a. Pert1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each run. Approximate tntervel Between Onset and Death Physician /Medical tmmediete Cause (Finel NARCOTIC INTOXICATION disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien the burle Box 68760, Physician/Medicai Due to (or as a consequence of): 080 23b. Did tobacco use contributa to the causa of death? P.O. Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert It. 1 Yes 2 No 3 Probably 4 Unknown signed to Records. Ď 24b. Were autopsy tindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☐ No Vital Attending Physician: funeral director. 8 25. Wes case referred to medicat 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Domer (Specification 10t 1 X Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA Jo this 28a. Date of injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? A Division 1 Naturat 5 Pending 24 hours efter death. Funeral Director: Aftiletaly filled in by the fun FOUND: FOUND: 1☐ Yes 21 No UNKNOWN investigation 2 Accident 28e-Piace of trijury At home, farm, street, factory, office building, etc. (Specify) FOUND: RESIDENCE OF FRIEND IN PARKING AREA 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) RT. 26 & DANCE HALL 4 Homicide 8 RD FREDERICK COUNTY, MARYLAND Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

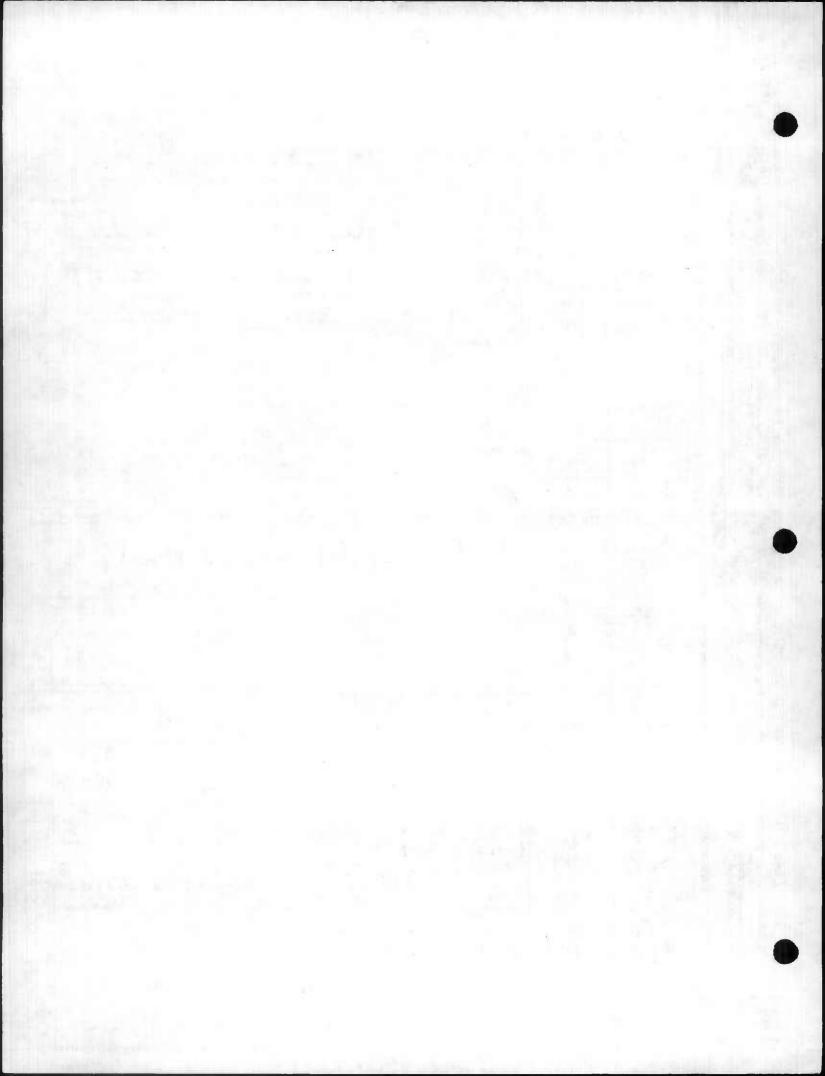
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. edicai 29e. Certifier completely (Check only one) within 2 29b. Signature and titte of certifier 29c. License number 29d. Dete signed (Month, Day, Year) O.C.M.E. February 27,2000 Olyme 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Merrisonos LORELL W) 111 Penn Street, Baltimore, Maryland 21 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 0 2 2000 Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

					Ce	rtificate o	r Death		Reg. No.		0001.
Physician /Medical	Decedent's Nam JOSEPI	ne (First, Middle, L H PAUL YO						2. Date of I Month MARCI	Day	Year	3. Time of Death 10:00 PM
Examiner	4e Facility Neme (LAUREI	(If not institution, g L BRANCH		umber)			4b. City, Tov POMO	wn, or Location of De NKEY		ty of Death	
Funeral Director	5. Social Security I 218-86-79		Sex 1ÇXM 2□ F	7. Age (In)	yrs. last birthday Yrs.	Months Day			Birth Day, Year)	9. Birth	place (State or Foreign ntr.) LAND
	Usual Residence of	_		1.0							
be notified at Director	MD	PRINCE	GEORGE		City, Town or L DXON HII						10d. Inside City Limits 1 ☑ Yes 2 ☐ No
1 5	10e. Street and Nu	imber				10f. Zip Code			10g. Citizen of	What Cou	ntry?
Funeral D	1154 AL	ICE AVENU	Æ, #1			20	745		UNITE	D STA	TES
by	11. Marital Status 1 Never Man 3 Widowed	ried 2□ Merried	Armed F	2 No	n U,S. 13.	Wes Decedent of If Yes, specify Co		gin? (Specify Yes or I , Puerto Rican, etc.)	No- 14. Ra Bla Speci	ice - Ameri ack, White, ity: BLA	etc.
Completed	(Spe	15. Decedent's I cify only highest g ondary (0-12)	rade completed,	(1-4or 5+)	(Give	dent's Usuel Occ a kind of work dor DO NOT use reti	ne during most red)		16b. Kind of I		
	17. Father's Name	(First heidelig des	41		MEAVY	EQUIPME	T		ADB AT		N
To Be	JOSEPH P	AUL YOUN	G, SR.				ALBEI	r's Neme <i>(First, Midd</i> RTA LUVENI	A KEY		
		leme/Retetionship						r or Rural Route Nun			
	ALBERTA		MOTHER	Jac		BOX 505	BRYAN	VS ROAD, M	T	206.	
		Cremetion 3 5 Other (Spec		Stete	cemetery, cre	osition (Name of metory or other p ANS CEME		3/10/00	20c. Location CHELTEI		MARYLAND
9000	21. Signature of Fi	uneral Service Lice 2/1/24 C. THORN	tory	MSON M		2. Name end Add HORNTON 439 LIVI	FUNERAI	L HOME, P.	A. DIAN HEAI) MI)	20640
ettending physician and for usa as the burtal-transit clan/Medical Examiner	Sequentially list or if any, leading to incause. Enter Und Cause (Disease or that initiated event resulting in death)	5	c	Due t	o (or as e conse	quence of):					
hyel	Part II. Other signif	ficant conditions	contributing to c	death but not	resulting in the	underlying cause	given in Part I.		id tobecco use c		to the cause of death?
by d								_	1		
Completed									as an autopsy rformed?	6/	fere autopsy findings vallable prior to empletion of cause deeth?
E								1	Ves 2□No	1	Yes 2□ No
	25. Wes case refer	rred to medicat					26 Place	of Deeth (Check onl			7.00 22.00
o Be	examiner?		Hospitel:	Inpatient :	2 ☐ ER/Outpatie	nt 3 DOA	Whor			ther /Saas	AT SCENE
cation: To	27. Manner of Deal 1 Natural 2 Accident		28a. Dete (Mor		28b. Time	of 28c. In		28d. Describ	e how injury occi		elf
=	Suicide 4 Homicide	6 Could not determine	28e. Plec build	e of Injury - / ding, etc. (Sp	At home, ferm, si	reet, factory, office	20	28f. Location City or 1	(Street and Nun Fown, State)	nber or Bur	al Route Number,
Medical Certi	29a. Certifier (Check only		miner: On the b					d place, and due to the hoccurred at the time			
N N	29b. Signature and	title of certified	feni	1)			o.C.M.	Ε	29d. Date sign	ed (Month,	
	30. Name and edde	ress of person who	completed cau	ise of death (et, Ba	ltimore, N	Maryland	2120	1
State egistrar	31. Date filed (Mon	MAR 06 2		Registrer's Si	gneture	Low	Ka/				



State of Maryland / Department of Health and Mental Hygiene

	Certificate of Death	Reg. No.	00 08820
Physician	Decedent's Nama (First, Middle, Last) A	2. Data of Death Month Dey	3. Time of Death
/Medical	An Mony Leonard Abricht 4a Facility Name (Major institution, give street and number) 4b. City, Town, or Lo	MARCH (1 2000 1544 County of Death
Examiner	Fallston General Hospital Fallsto	4/ 2	Lapland
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Dete of Birth (Month, Day, Year)	9. Birthplace (State or Foreign
Director	Usual Residence of Decedent	Nov 20, 19	18 Maryland
how	10a. Stete 10b. County 10c. City, Town or Location		10d. Inside City Limits
er deeth with the Meryland Nems 23a or 28af show ner must be notified at Uneral Director	Md Harford Belder		1 □ Yes 2 No
with the Cor 2		10g. Citiz	en of What Country?
offer deeth ver Herne 23 obser ment	11. Marital Status 12. Was Decedent Ever in U.S. Amped Forces? 13. Wes Decedent of Hispenic Origin? (Sp. If Yes, specify Cuben, Mexican, Puerto	ecify Yas or No-	4. Race - American Indian,
020 ura est	3 Widowed 4 Divorced Year or Delas: 1 Yes 2 No Specify:		Black, White, etc. Specify: White, etc.
121215-0020 ed within 72 hours ef vylene. For then "netural", or the model of the Completed by F	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of work	rina 💮	d of Business/Industry
2121 d within plene.	Elementary/Secondary (0-12) College (1-4or 5+)	MIDD JER	LVICE STATION
and 2	17. Father's Name (First, Middle, Last)	e (First, Middle, Maiden S	Sumame)
laryian 2 ahould be end Mentel le merked o eumatic ev	deanard & Albrecht dea	hB.M	Clain
	19a. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Run 19c. Informant's Neme/Reletionship (Type, Print)	al Route Number, City or	Town, State, Zip Code)
EZML	20a. Method of Disposition 20b. Place of Disposition (Name of	Dete 20c. Loc	ation - City or Town, Stete
Baltimore, semit. Pega 1 e Begannen of Her	1 Maurial 2 Cremetion 3 Removal from Stata Donation 5 Other (Specify)	2000 PAR	Krille Mapyland
Salt emil. epart ny inj	21. Signature of Famerel Service Licensee 22. Name and Address of Facility	vans Fun	eral Chapel
M TORES	Jesta Le Jell 8800 Harlord	Rd Bal	timore Md 21234
Physician	233. Part it Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac shock, or heart feiture. List only one cause on each line.	or respiretory errest,	Approximate Intervel Between Onset and Death
(Medical	Immediate Cause (Finel disease or condition		2 wks
Examiner	resulting in death) Due to (or as a consequence of):	/	1 140
	b. Pertorated duodonal i	nleer	16 WKS
68760, A filtere be executed the burieltranel set the burieltranel edical Examile	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or es a consequence of): Due to (or es a consequence of):		
68760, Micete be exe up physician as the buriel-	Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of):		
	d		
Records, P.O. Box The law requires that the death cert tite has been signed by the ettending togge 2 should be detached for use.	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23h Did Johacco I	use contribute to the cause of death?
P.O. thethe described by the	C. 1 .		N6 3 Probably 4 Unknown
	CICCHOSIS		
A Completed by Completed by		24a. Was an autopoperformed?	available prior to completion of cause
The lew see here		1□ Yes 2□	of death?
	25. Wes case referred to medical 26. Plece of Deat	th (Check only one)	10165 2010
Of Vita Physicien: rthis certification, and director,		ome 5 Residence 6	□Other (Specify)
After the funeral funeral funeral	Pending (Month, Day Year) Injury Work?	28d. Describe how injury	occurred
Division for Attending after deeth. Director: After d in by the tune	3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, factory, office	28f. Location (Street and	Number or Rural Route Number,
Division (set or Attending P as a pre-deeth. al Director: After t ied in by the funen Certification:	4 ☐ Homicide building, etc. (Specify)	City or Town, State)	
To the Hospital or within 24 hours after the Funeral Incompletely filled in Medical Cert	29a. Certifier (Check only 2 Medical Examiner; on the best of my knowledge, deeth occurred et the time, dete and plece, 2 Medical Examiner; on the basis of examinetion end/or investigation, in my opinion, deeth occurred	end due to the ceuse(s) red at the time, date and	and menner as stated. place, and due to the cause(s)
o the comple omple	one) And thanner steled. 29b. Signature and that of certifier 29c. License number	29d. Dete	e signed (Month, Day, Year)
- sto	1 196 X X 1 MO D47463	Mar	ch 15,2000
10	30. Name and address of person who completed cause of seath (Item 23a) (Type, Print)	2 1 2	->
	31. Date filed (Month, Day, Year) 32. Registral's Signature	1d. 2105	O
State Registrar	MAR 1 6 2000 Server D. Aparles		

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08821 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Jesse James 2000 Arney 10 12:20 PM March /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Mariner Health of Forest Hill Forest Hill Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1⊠ M 2□ F VIRGINIA Director 218 29 1155 Dec 2, 1928 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director MARYLAND MARFORD FORIST 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 U.S.A.

14. Raca - American Indian, "natural", or items 23s KOAO 21050 Ords Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No 1 Never Married 2 Married If Yes, Give Year or Detes: 1 Yes 2 No Specify: à 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important if Rem 27 is marked other than any injury or other traumatic Elementary/Secondery (0-12) College (1-4or 5+) HARFORD LOUNTS 10 YRS. INSPECTOR 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ARMEY KUTH FLANIGAN William FRANKLin 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARYLAND BETTY L-AROSY TAT FOREST HILL 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p MARUH 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 □ Removal from State HIGHVIEW DEM. GARDENS 13, 2000 FALLSTON 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CHAPSI - BILAIR, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause of each line. MARYLAND FORES Approximete Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical LTM Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of) Physician/Medical the Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? TA Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 SNetural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State)

certificate be executed physician and the bunal-tran Box 68760. detached Records, P.O. signed by the detach page 2 s certificate Division of Vitai or Attending Physician: this After death. Director 24 hours after d Hospital edical

the Maryland

72 hours after

Saltimore, Maryland 21215-0020

Certification: To

within 2. To the F

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

29c. License number

D32296

29d. Dete signed (Month, Day, Year) marcol+ 10, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615 Dav. D www W

31. Date filed (Month, Day, Year) State Registrar MAR 1 6 2000

4 Homicide

29a. Certifier (Check only one)

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

et:

Physician

/Medical

Examiner

Funeral

Director

rai', or items 23a or 28s-f ahor Examiner must be notified at

"natural", or

er than "nature,

7 is marked other traumatic event, I

Hygiene.

Peges 1 and 2 should be 1 and 2 should be 1

the Maryland

72 hours after death

5. Social Security Number

10e. Street and Number

3rd Grade

20e. Method of Disposition

Immediate Cause (Finel diseese or condition resulting in death)

1 Yes 2 No

27. Menney of Death

1 Neturel

2 Accident 3 Suicide

4 Homicide

(Check only one)

MAR 1 6 2000

30. Neme end eddress of person who completed cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signature

29a. Certifier

11. Marital Status

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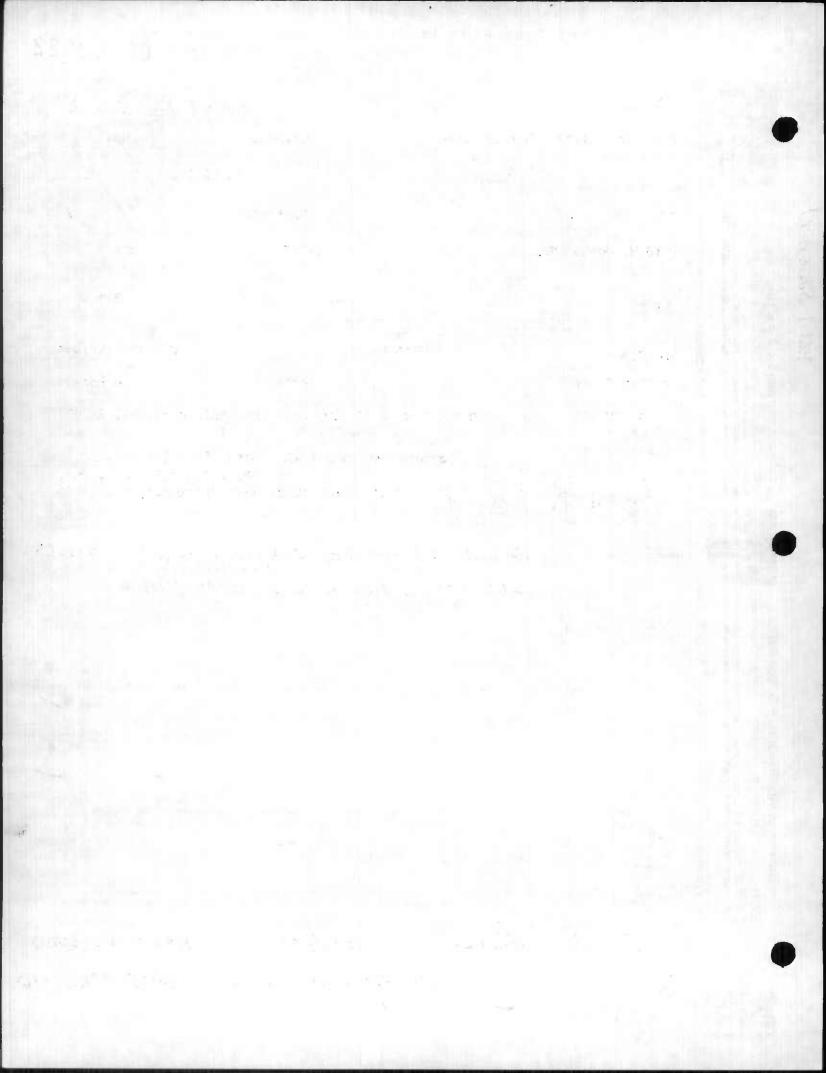
State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Defe of Death 84 Ella S. Brogden 13 MARCH 2001 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Villa St. Michael Nursing Home Baltimore n/a If Under 1 Yeer 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 1 M 2 Months Days Hours 100 Yrs. April 15, 1899 Md Usuel Residenca of Decadent 10h County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 to Yes 2 □ No 10f. Zip Code 10g. Citizen of What Country? 1918 W. Mosher Street 21217 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Defes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Domestic Private Families 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Name (First, Middle, Last) Charles Simms Annie unknown 19b. Melling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informent's Name/Reletionship (Type, Print) Sharon Dutton grandaughter 3214 Blue Hill Road Baltimore, Md. 21207 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 1 Surial 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) March 18 Baltimore, Md. Arbutus Memorial Park 22. Name end Address of Facility Nutter Funeral Homes, Inc. 21. Signature of Funerel Servica Licensee 2501 Gwynns Falls PKWY Baltimore, Md. 21216 weeth. Do not enter the mode of dying, such es cardiec or respiratory arrest, Approximete Intervel Between Onsef and Death 4 WEETCS STAGE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequenca of): 23b. Did tobacco use contribute to the cause of death? Pert II. Other stanificent conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 3 Probably 4 Pronknown 1 Yee 2 No 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 Yes 21000 1 ☐ Yes 2 ☐ NO 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury et Work? 5 Pending Investigation 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the cause(s) and menner es steted. 2 Medical Examinar: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number MARCH 13, ZOUD

PAMIC HEIGHTS AVE BALTIMORE, MD

permit. Peges 1 and 2:
Department of Health ar
important: if Nem 27 is
any injury or other trau Baltimore, **Physician** /Medical Examiner the death certificeta be executed Division of Vital Records, P.O. Box 68760 or Attending Physician:

funeral Certification: ofter death Director: / within 24 hours oft To the Funeral Di completaly lilled in Medical To the To the To the

Registrar



State of Maryland / Department of Health and Mental Hygiene 10 18823

**************************************	KATHRYN F. BOR Facility Name (If not institution, g GILCHRIST HOSPI Social Security Number 213-46-8096 Joual Residence of Decedent On. State 10b. County MD Howar On. Street and Number 3608 Quaker Mill Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced (Specify only highest g Elementary/Secondary (0-12) 12 7. Father's Name (First, Middle, Last Anthony J. Chun	RSONI Investment and number) ICE CENTER Sex 7. Age (I) I M 2 M F To Age (I) I Uses Decedent Even Armed Forces? I M Yes, Given Year or Dates: Education	53 Yr Oc. City, Town o	or Location 1 icott 10f. Zig	r 1 Year Days	TOWS	wn, or Lo	Month MARCH cation of Deat	10, 200 th 4c. Court BAL	oty of Death	RE	
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20s. Method of Disposition Spiral 2 Comment 3 Removal from State												
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21. Signisher of Euheral Sprices Licensee						;e)	1	Date	200. LOCATION	1 - Ony or 1	own, ordie	
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1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 29d. Date signed (Month, Day, Year)		1 L Inpatient	1 inpatient 2 LEVOutpatient 3 DOA 4 Norsing Home 5 Hesidence 6 potner (speciny) 1701 pt									
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(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	3 ☐ Suicide 6 ☐ Could not	d 28e. Place of Injury								mber or Ru	rai Route Numbe	
29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)	(Check only 2 Medical Exp	iminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s)										
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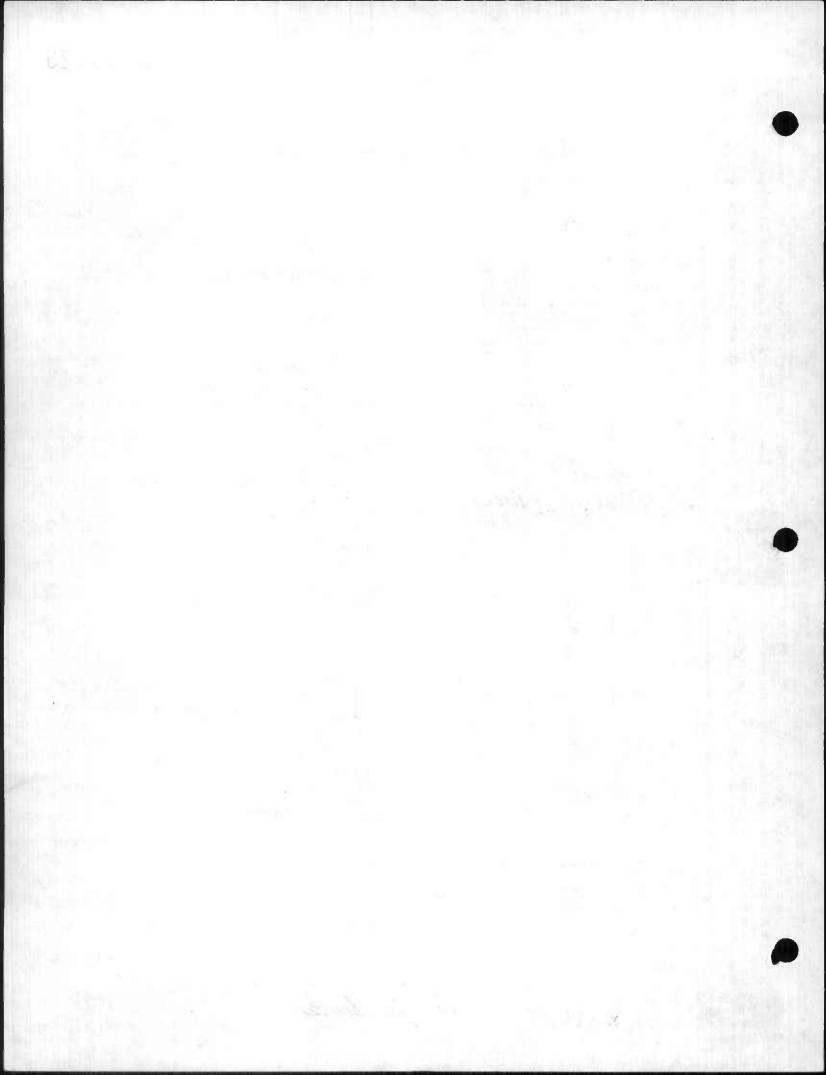
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Corsoni March 10,2000

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Division of Vital Records, P.O. Box 68760,

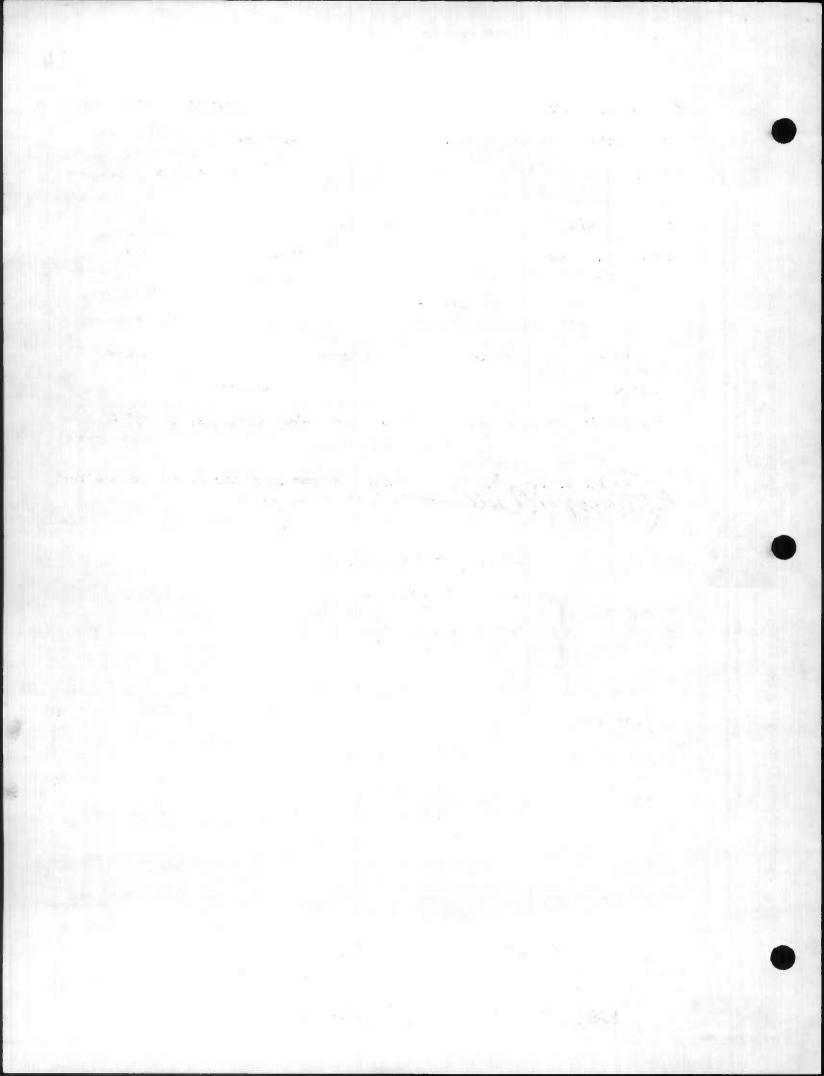
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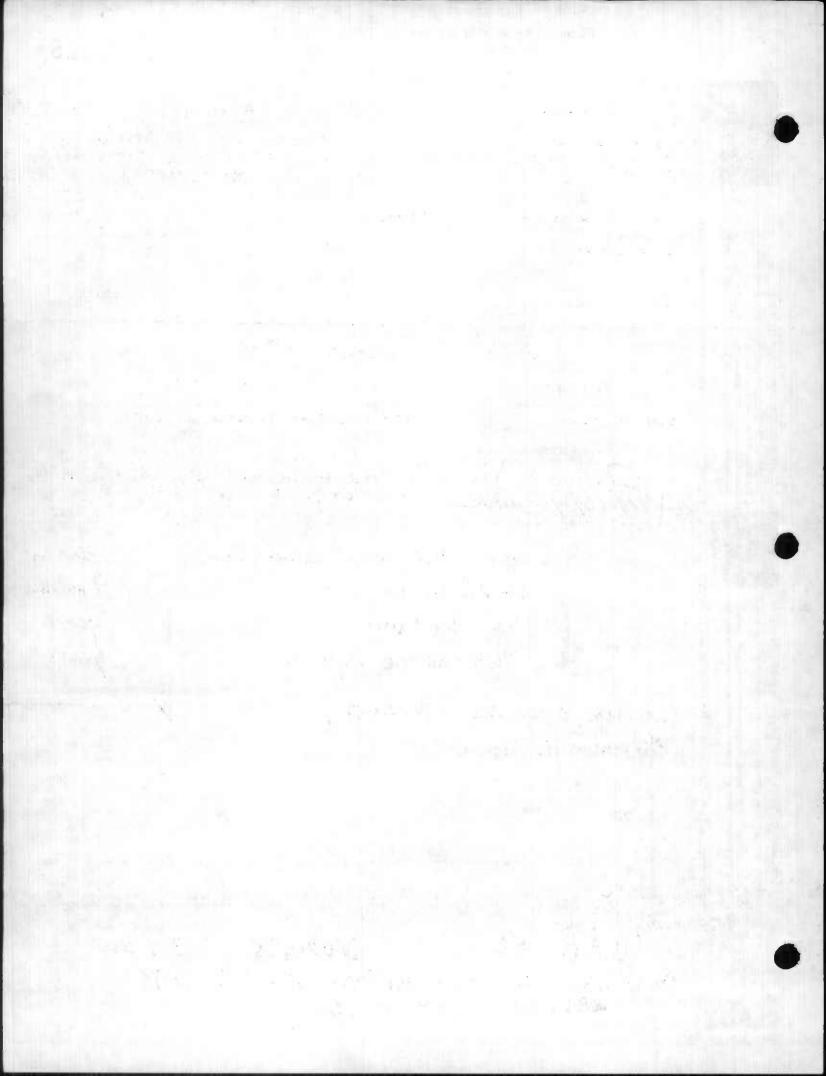
State of Maryland / Department of Health and Mental Hygiene O O

	1	1. Decedent's Neme (First, Middle, Last)							2. Date of Deeth				. Time of Death	
Physicia /Modie	n	CHARLES BRUGGEMAN								FEBRUARY 1, 2000 6:			6:31 PM	
/Medica Examine		4a Facility Neme (If not institution, give street and number)							4b. City, Town, or	n, or Location of Death 4c. County of Death				
** I		Johns Hopkins Bayview Medical							Baltin					
Funeral Director		Social Security Nunknown Isual Residence of		6. Sex 1∭ M 2□ F	7. Age (In yrs. 60	last birthday) Yrs.	If Under Months	Deys		Hours Min. B. Date of Birth (Month, Day, Year) Jan 20, 1940 9. Birthpleca (Country) unknow			(State or Foreign	
show	1	Oa. State	10b. County		10c. Ci	ty, Town or Lo			10d. Inside City Limits 1 ☑ Yes 2 □ No					
Ne M	ect.	MD 0e. Street and Nu	N/A			Bal	ltimor				10g. Citizen of V		21	
23ª or	ral Dir	4629 Ka	yon Ave				10f. Zip		21206		U	SA		
To find you with the Maryland 2 and 2 should be filed within 72 hours after death with the Maryland female and Mentel Hygiene. The marked other than "naturel", or items 23 or 28s-f show other traumetic event, the Medical Execution must be notified at Other traumetic event, the Medical Execution must be notified at To Be Completed by Funeral Director	by	Marital Stetus Never Marital Widowed	ried 2□ Mari	ried 1 Tes	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: unknown					14. Race - American Indian, Black, White, etc. Specify: White				
	ompleted	(Spec	ondary (0-12)		College (1-4or 5+)			Jsual Occupation f work done during most of working T use retired) nknown			16b. Kind of Business/Industry unknown			
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	To	unknov	√n						ur	known				
and 2 should saith and Men n 27 is marks er traumatic										or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD 21224				
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/Medical Examiner		mmediate Cause disease or condition esulting in death)	on	a. Coro	NATY Due to (Artery oras a consec brillat	Quence of):	eas	Ĝ			-	o years	
	8 '	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Couse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): CATOLIO MYD PATHY Due to (or es a consequence of):												
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that the deeth cered by the ettendin detached for use	y Phys						moonymg oc	ouse gr	voir iir r divi.		Yes 2 No			
that the	2	Hyperligidemia											autopsy findings	
lew requires that the ses been signed by a 2 should be deter	nplete	Hyperl	igidemi	٥						24a. Was perlo	an autopsy rmed?		ble prior to letion of ceuse th?	
The lew requires that the cata has been signed by page 2 should be detected.	Completed by Physician/M	Hyperl	ig.demi	ν							rmed?	comp	etion of ceuse th?	
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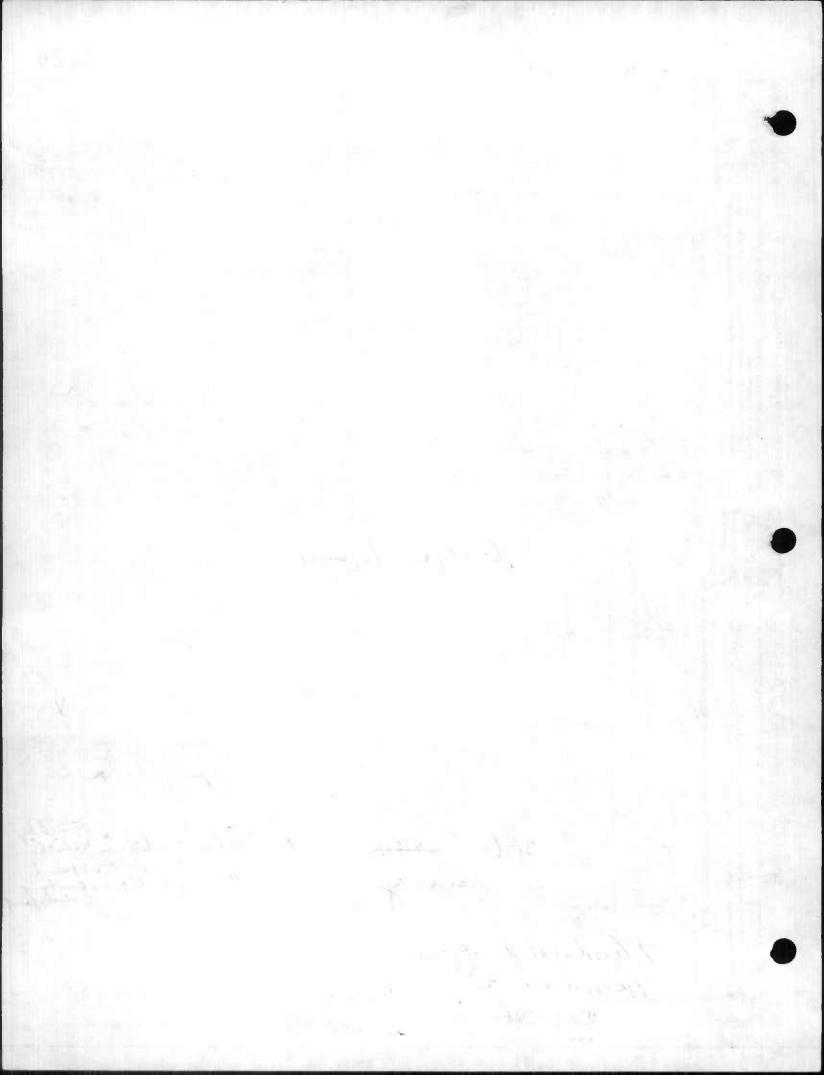
		1. Decedant's Na	ama (First, Middle, Last,)							e of Deeth			3. Tima of Death	
	Physician	Al	NNA M. BLEY								MARCH 6, 2000		Yaar 1:27 AM		
	' /Medical Examiner	An English Stamp (Mant institution when stands and numbers)						4b. City, Town, or Location							
A	Examiner	13 G	orsuch Road			Timonium			ım	Baltimo			more		
	Funeral	5. Social Security	Number 6. Set	Aga (In yrs. le	est birthday)	if Under 1	Year	If Under 24 Hours	Hrs. 8. Det	e of Birth orth, Dey, Y	(ear)	9. Birth	piece (Stete or Foreigntry)		
	Director	215-14-0 Usuel Residence	1545	91	Yrs. Sept 2,					1908		MD			
	show	10a. Stete										10d. inside City Limi			
	the Ma	MD	Baltim	ore		Timonium						1 ☐ Yes 2 💢 N			
	with wo	10a. Street and N	such Road			10f. Zip Code 21093					10g. Citizen of Whet Country? USA				
20	hours effer death urel', or fleme 23 IL sammer must		arried 2 Married	12. Was Decedar Armed Force 1 Yes 2 If Yes, Giva	s? X No	U.S. 13. Wes Decedent of Hispanic Origin? (Specify Yas or if Yes, specify Cuban, Mexicen, Puarto Ricen, etc.) 1 □ Yes 2X No Specify:					s or No- etc.)	No- 14. Race - Americen Indien, Bleck, White, etc. Specify: White			
21215-0020	houn houn		15. Decedent's Edu	Yeer or Deter	s:	16a Doord	lant's Heural	Occup	ation		10	Sb. Kind of B	usinasali	adueto	
15	in 72	(Sp		16a. Decedent's Usuel Occupation (Give kind of work done during most of work) life. DO NOT use retired)				f working		oc. Kind of D	USII IASWII	loustry			
212	bygiene. The than "neture the Medical of the Medic	Elementery/Se	condery (0-12)	College (1-40 unknown		housewife					none			e	
	be filed tal Hygin d other event,	17. Fether's Nem	e (First, Middle, Last)			18. Mother's Name					e (First, Middle, Melden Sumeme)				
lar	Menta	Willia	William F. Lower							Carrie	e E. Mahr				
Maryland	and harman		Neme/Reletionship (Ty			_						, Stete, Zip Code)			
	end 2 n 27 ll	Elmer	Bley/son					Road '	Timoni	um, M	D 210	193			
Baltimore,	Peges 1 ent of He nt: if item ry or oth	20e. Method of D 1 Duriel 4 Donetion	0.0	Place of Disposition (Neme of cematery, cremetory or other place)					Dete 20c. Location - City or Town, Stata			own, Stata			
Balti	permit. Pe Departmen Important: any injury once.	21. Signature of Fundal Service Sicentified e, Director 22. None and educated Man of Evident Board 655 W. Baltimore Str. Baltimore, MD 21201												re Street	
1	Physician /Medical Examiner	23a. Part1. Ente shock, or hi immediate Ceus disease or condi resulting in deeth	tion	loations that ceus ne cause on aach	sed the death			•	ng, such es ce			st,	1 1 1	Approximete Interval Between Onsat and Deeth	
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Box	eath cert for use			to im	moru	_ vie	1/4	41/10			1700.3				
	0 0 0	Part II, Other sign	nificant conditions cor	tributing to death	n but not resu	Iting In the ur	nderlylng cei	use aiv	ren In Pert I.	23	b. Did tob	acco use co	ontributa	to the cause of deat	
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Records,	been shoul	thro	embo cyt	open	ia						e. Wes en perform	rformed? available p		Vera eutopsy findings vaileble prior to completion of ceusa of death?	
	The lev page 2			V							1 🗆 Yes	2 NNO	1	□Yes 2 No	
ita	certificate rector, pag	25. Was cese ref	ferred to medical						28. Place of	Deeth (Chec	k only one)			
of Vital		exeminer?	No I	fospitel:	atient 2 E	ER/Outpatien	t 3 DOA	Oth	er: 4 Nurs	ing Homa 5	Residen	ice 6 Oth	har (Spec	eify)	
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Ö	Attending r deeth. octor: After by the fune	1 Neturel 2 Accident				,	М		Yes 2□No						
Division	l or Atta after de Directo J in by t	3 Suicida 4 Homicida	6 Could not be determined	28e. Plece of building,	Injury - At hore	me, ferm, str	eet, fectory,	office			cation (Strey or Town,		ber or Ru	ral Route Number,	
۵	To the Hospital or Attending P within 24 hours after deeth. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	29a. Certifier (Check only	Certifying Physical Examination	sician: To the be	st of my know	vledge, death	occurred et	the tir							
	Within 24 Within 24 To the F complete	one)	-	end menner	steted.										
	To Too	29b. Signatura	A COUNTY	11 1					e number	2-0	29	Dete signe	1 -	n, Day, Year)	
		1	agin	min,			D	DU	3499	58		2.1.	200		
		30. Neme end and	a · Planeys	mpleted cause o	10753	23e) (Type,	1d #3	25,	3499 Cuthe	ville, a	Ud - 2	21093			
	State Registrar	31. Dete filed (Mo	onth. MARa1 6	2000 32. Regi	strar's Signet	ure	4.	po	rela						



00-1353-027		d / Department of Health and I	Mental Hygiene 00 08826						
Barry Buckman	Amended Item#28b perPhyG781 3/16/2000 EV	Certificate of Death	Reg. No. 2. Date of Death 3. Time of Death						
Physician	Barry Donald Buckman		Month Day Year						
/Medical Examiner	4e Facility Name (If not institution, give street and number)	March 09 2000 12:38 A.M.							
	Route 29 westbound @Route 100 Ra	emp Fllicott	City						
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. le	ast birthday) If Under 1 Year Til Under 24 Hrs. Months Days Hours Min.	City Howard 8. Date of Birth (Month, Day, Year) Apr. 14 1954 New Jersey						
Director	217-64-6361 45 Usual Residence of Decedent	Yrs.	Apr 14, 1954 New Jersey						
enyland show		, Town or Location	10d. Inside City Limits						
the Meryle 28a-f sho notified at	MD Howard H	Ellicott City	1 ☐ Yes 2 No						
or 28a-f	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?						
oth w	9210 Furrow Avenue	21042	United States						
Maryland 21215-0020 d 2 should be filed within 72 hours effer death with the Meryland in bind Mental hygiena. T la marked other than "natural", or frame 23a or 28a-1 show traumatic event, the Medical Earther must be hothlised at To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 12. Was Decedent Ever in U,S Armed Forces? 1 Yes, Sive Year or Dates:	 Was Decedent of Hispanic Origin? (S if Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify: 	pecify Yes or No- lo Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White						
1 21215-0 led within 72 ho bygiena. Nor than "naturn rt, the Medien Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during most of work	16b. Kind of Business/Industry						
mple mple	Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of wor life. DO NOT use retired)							
D Hardy	17. Father's Name (First, Middle, Last)	Salesman 18. Mother's Ner	Hardware me (First, Middle, Maiden Sumame)						
Viance void be fill whether the worker out the event	Donald E. Buckman		na D. McClain						
ore, Maryland 212. ges 1 end 2 should be filed withit to Hamally and Mental hygiena. If than 271a marked other than or other traumatic event, the Mental hygiena. To Be Comp	19a. Informant's Name/Relationship (Type, Print)		ural Route Number, City or Town, State, Zip Code)						
G, M. 1 end 2 Hazith am 27 lether tra	Donald E. Buckman/Father	9210 Furrow Avenue El	licott City, MD 21042						
Baitimore, emit. Pages 1 en opperment of Hear moortant: if han 2 ny Injury or other total.	20a. Method of Disposition 20b. Place 1 Burial 2 Dicremation 3 Removal from State	ace of Disposition (Name of metery, crematory or other place)	Date 20c. Location - City or Town, State						
time ment luny of luny	4 Donation 5 Other (Specify) Met	3-11-2000 Catonsville, MD							
Baltime permit. Pag Department Important: It any Injury o	21. Signature of Funeral Service Licensee A O LO Y Y 22. Name and Address of Facility Harry H. Witzke's Family Funeral Home, I 4112 Old Columbia Pike Ellicott City, MI 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, when the shock, or heart failure. List only one cause on each line.								
lew requires that the death certificate be executed as been signed by the attending physician end was been signed by the attending physician end as a should be deteched for use as the burfal-transit any physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	as a consequence of): as a consequence of):							
O. Box 6 a death certifi the attending had for use a	Part II. Other significant conditions contributing to death but not result	23b. Did tobacco use contribute to the cause of death?							
ds, P.O. Box 6i			1 Yes 2 No 3 Probably 4 Unknown						
Vital Records, idean: The lew requires the conflictate has been signe rector, page 2 should be completed by			24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?						
E a tage			1 1 10 1 1 1 No 1 No						
Vital Incoming the Contillege Tractor, page Co	25. Was case referred to medical examiner?		nth (Check only one)						
五 章章 P			tome 5 ☐ Residence 6 ☐ Other (Specify) S CEDE						
Oivision or Attending after death. Director: Attending in by the funestill of the funestill	1 Natural 5 Pending investigation 3 9 Day Year)	Injury 1238M Work? 1 Yes 24 No	201. Location (Several and Number or Byral Royte Number of States) 201. Location (Several and Number or Byral Royte Number of States) And Andrew House of Courts Andrew Hou						
he Hospital no 24 hours he Funerel pletely filled	29a. Certifier (Check only one) Cartifying Physician: To the best of my know 25 filedical Examiner: On the basis of examination and manner stated.	ledge, duff occurred at the time, date and place on and/or investigation, in my opinion, death occurred	o, and due to the cause(s) and manner as stated. where d at the time, date and place, and due to the cause(s)						
To the within 8 To the comple									
State	31. Date filed (Month, Day, Year) 32. Hopistrar spigment		Baltimore, Maryland 21201						
Registrar	MAR 1 6 2008 Dene	D. sports							

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended item#29d perPHYG781 3/16/2000 EW Reg. No. 1. Decedant's Nema (First, Middle, Last) 2. Date of Death Month **Physician** Dorothy Adell Barnes 12, March 2000 12:15 pm /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1739 Colora Rd. Colora If Under 24 Hrs. 5. Sociel Security Number 7. Age (In vrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Deys 1 ☐ M 2 🗙 F Months Hours 212 26 5291 70 Yrs Jan. 21,1930 Director Maryland Usual Residence of Decedant the Maryland 10a State 10b. County 10c. City. Town or Location ral", or items 23a or 28a-f ahow Examiner must be notified at 10d. Inside City Limits Maryland Baltimore 1 Yes 2 No Director Middle River 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 31 Henderson Rd. 21220 USA Funeral deeth 12. Was Decedent Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yes, Giva Year or Detas: Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, 11 Marital Status Bleck, White, etc. filed within 72 hours after 1 □ Never Merried 2 □ Merried 21215-0020 natural', or 1 Tyes 2X No Specify: White by 3 DXWidowed 4 □ Divorced Hygiena. other than "naturn Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Housewife Own Home 8 Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be file ment of Heelth end Mental Hy lant: If item 27 is marked oth jury or other traumatic even John Henry Stevens Adell Johnson Margaret 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. intorment's Neme/Reletionship (Type, Print) Mary Rinel (Daughter) 1739 Colora Rd. Colora, Md. 21917 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Department of important: If any injury or pace. Holly Hill Mem. Gardens 3/15/2000 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, Md. 22. Neme and Address of Fecility
Bruzdzinski Funeral Home P.A. 21. Signature of Funerel Service Licensee 1407 Old Eastern Avenue Essex, Md. 21221 1. Enter the disease, or complications that caused the deeth. Do not enter tha moda of dying, such as cardiec or respiratory errest, k, or heart failure. List only one cause on each line. Approximate intervel Between Onset and Death **Physician** STIOLOGY UNKNOWN /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es a consequence of): Examiner Sequentielly list conditions, if any, leading to immediate cause. Entar Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Box 68760. Physician/Medical physis the t Due to (or as a consequence of): for use P.O. Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No The lew requires that Records, by 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy page 2 certificate has 1 ☐ Yes 2 DXNo 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence Sweller (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Yes 2 No this funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Time of injury 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Netural after death. Director: Af 1 Yas 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide 24 hours a Hospital 29a. Certifier Medical 1X Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examiner and menner steted. (Check only one) ninetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 200 29b. Signeture end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) 3/13/2000 ne and address of person who completed cause of deeth (Item 23e) (Type, Print)

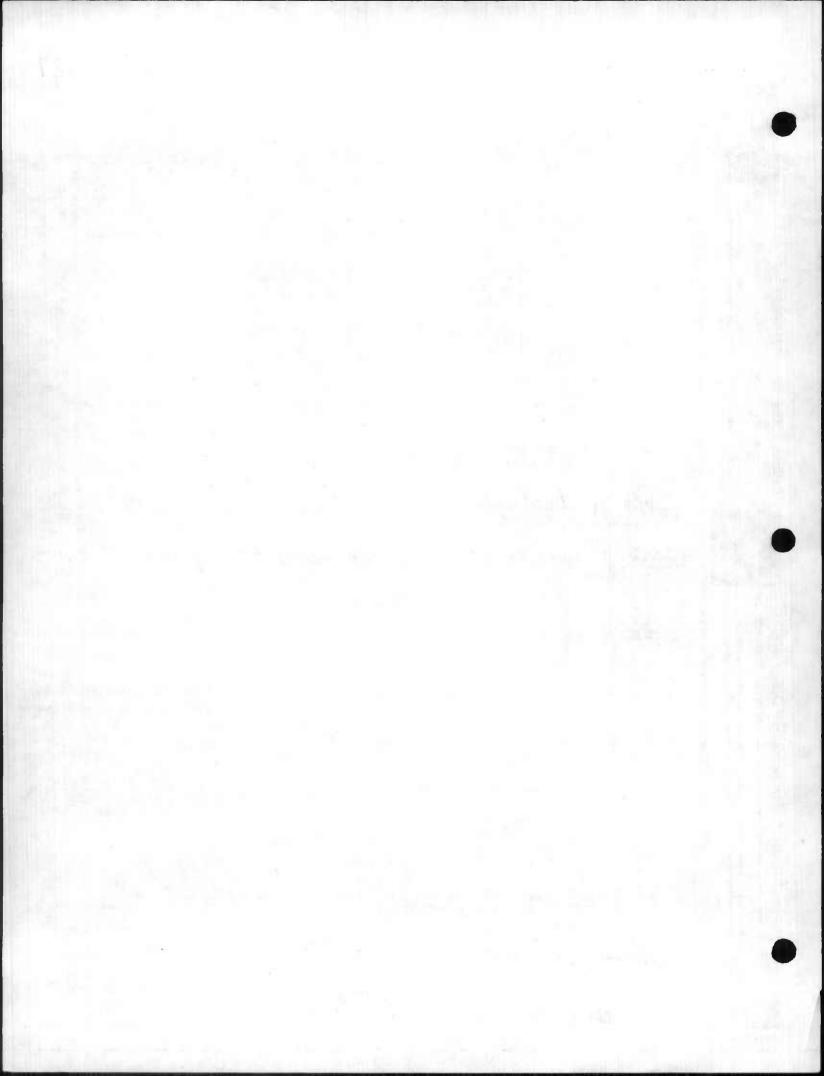
Registrar

State

31. Dete filed (Month, Dey, Year)

MAR 1 6 2000

32 Registrar's Signeture



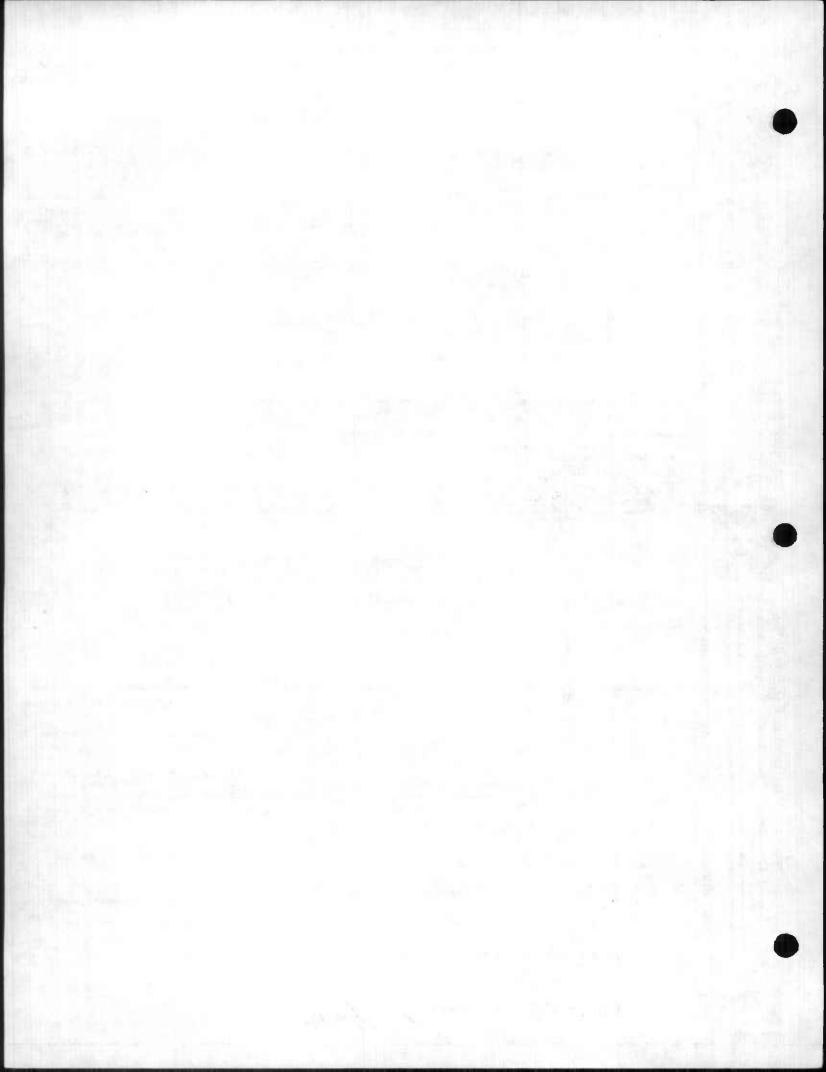
State Registrar Stephen S. Ra.
31. Date filed (Month, Dey, Year)
MAR 1 6 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Radentz

32. Registrar's Signeture reperson

111 Penn Street, Baltimore, Maryland 21201



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month **Physician** E 11:30 P.M. GENE CARTER TEBRUAR & TWENT 1874 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE HOSPITAL OF BALTIMORE SINAL H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Jan 24, 1941 6. Sex 1 M 2 □ F If Linder 1 Year Birthplace (State or Foraign Country)
 NTV 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 59 NY Director 378-40-5384 Usual Residence of Decedent the Meryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or frame 23s or 28s-(show the Madical Examiner must be notified at 1 Yes 2 No Director Baltimore MD N/A 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? death with USA 21215 5713 Simmonds Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Rece - American Indian, Black, Whita, etc. Peges 1 and 2 should be filed within 72 hours effect ont of Health and Mental Hyglene.
Artif flem 27 is marked other than 'natural', or hearly or other trauming event, its Medical Emmin 1 ☐ Never Married 2 ☐ Married Specify: black Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: g 3 ☐ Widowed 4 1 Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) unkirown 5+) state construction 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) B unknown unknown 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Sinai Hospital 2401 W. Belvedere Ave Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete permit. Pege Department of Important: If any injury or pace. 4 ☐ Donetion 5 ☑ Other (Specify) 21. Signature of Funeral Service Licensee in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Ronald S. Director 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, spock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical PLLMONARY DISEASE EXACERBATION CHRONIC OBSTRUCTIVE Examiner Due to (or es a consequence of): Examiner ician and buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): physician s the buriel Box 68760, Physician/Medicai Due to (or es a consequence of): 080 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☑ Probably 4 ☐ Unknown CORONARY ARTERY DISEASE Records, g 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 2 1 No 1 Yes 1 Yes 2 No Division of Vital or Attending Physician: funeral director, 25. Wes case referred to medical examples? B 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 1 Ves 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To After this 27. Manger of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how Injury occurred 28c. Injury at Work? 1 Metural 5 Pending To the Hospital or Attendir Within 24 hours efter deeth. To the Funeral Director: At 1 Yes 2 No invastigetion 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the cause(s) and mannar as steted.

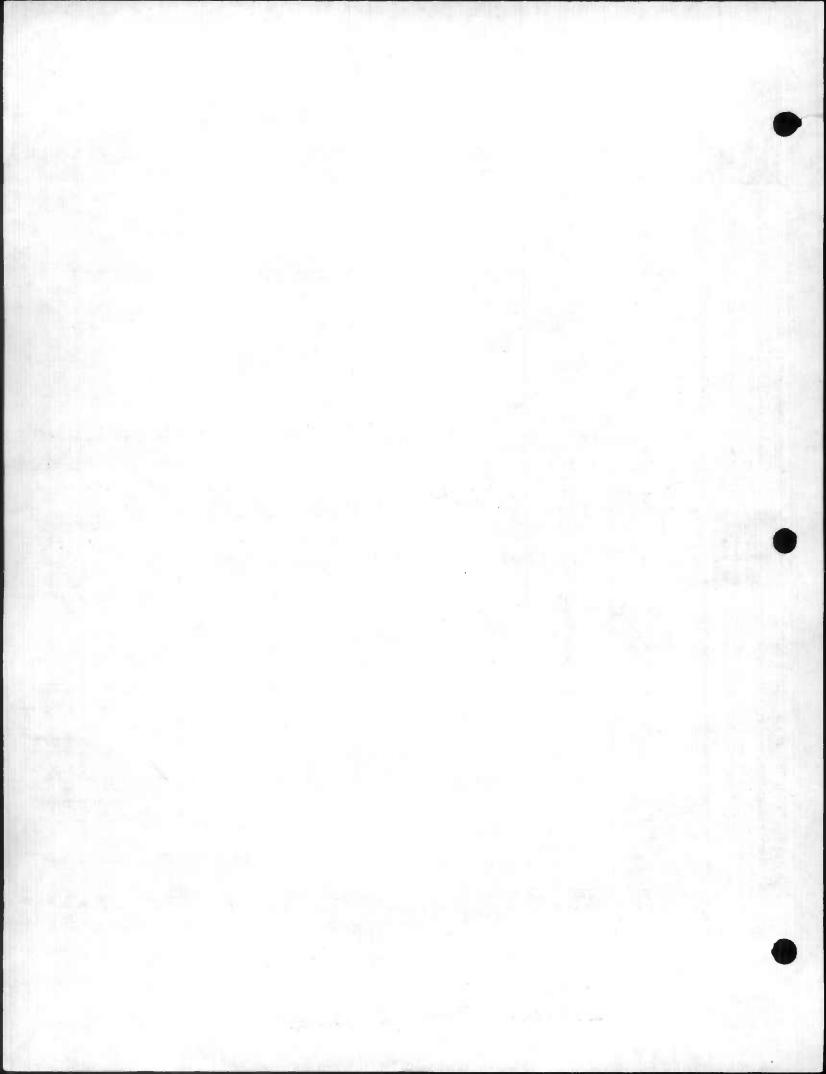
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end plece, and due to the cause(s) end menner steted. edical 29a. Certifier within 24 hor To the Fune completely fi (Check only one) 29b. Signatura and title, of certifier 29c. License number 29d. Data signad (Month, Day, Year) Navi, MD P11243 TEBRUARY TWENTIETH 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GIRISH NAIR, M.D. 2401 WEST BELVEDENVE AVENUE BALTIMORE, MARYLAND 21215

DHMH 16 Rev 6/95

State Registrar

31. Data filed (Month, Day, Year) 32. Registrar's Signeture MAR 1 6 2000 >

Deneron



Funeral Director

Baltimore, Maryland 21215-0020

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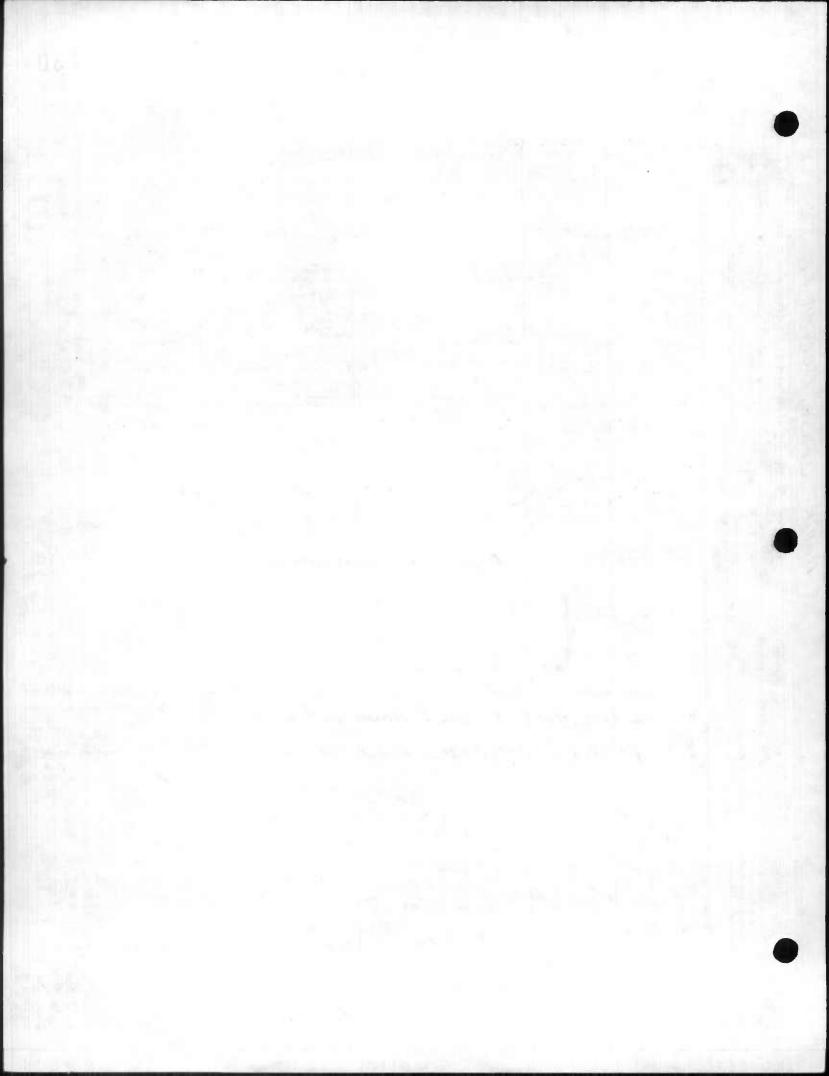
Truse,

VAME:

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal Irom State 4 ☐ Donetion 5 ☐ Othar (Specify) 3/16/00 Hilltop Service Corp. 21. Signature of Poneral Service Licen-22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine physician and the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated evants resulting in death) Last Due to (or es a consequence of): Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause givan in Pert I. Records, P.O. Forther DAminita Deorg Completed by 24a. Was en autopsy performed? 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Yes 2 No Other: 4 Nursing Home 5 Rasidence 8 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Menner of Death 28b. Tima of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t NA or Attanding 1 Neturel 5 Pending investigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Yas 2 No 2 Accident NA NA 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify) 4 ☐ Homicide 1th Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end manner stated. 29a. Certifier Medical (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 2 ND SUS Tonion Mich 21204 Lofez bellong 31. Dete liles (Month, Par Ager) 1 6 Registrar **DHMH 16 Rev 6/95 ORIGINAL**

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dev **Physician** BERTHA LOUISE CRUSE 4:45PM MARCH 14, 2000 /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE 8. Dete of Birth (Month, Dey, Year) Dec. 15, 10 If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 M 2 S F 212-01-2465 Usual Residence of Decedant 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits pemit. Pages 1 and 2 should be filed within 72 hours after death with the Manyan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any Injury or other traumatic event, the Medical Examinar must be notified as 1 ☐ Yes 2 ☑ No Director Baltimore Towson 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 800 Southerly Rd. 21286 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11 Maritel Status Bleck, White, etc. 1 Never Merried 2 Merried 1 Yes 2 No Specify: p 3 ₩ Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Certified Public Accountant Accounting 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Frederick William Ortman, Sr. Bertha Louise Baltz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Nephew Mr. Frederick W. Ortman, III 2508 Stonebridge Rd. Dothan, Alabama 36301 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Towson, Md. 21204 Approximata Intervel Batween Onset and Death 72 hous 23b. Did tobacco use contribute to the cause of death? 1 Yee 20 No 3 Probably 4 Unknown 24b. Wera autopsy lindings evailable prior to complation of cause of death? NA 1 ☐ Yes 2 ☐ No

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene



Please Type or Print in Biack Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year OSE CZERWINSKI March 14, 2000 6:00 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Dulaney Towson Nursing Home Baltimore Towson If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 ☐ M 2 🖫 F Months Yrs. 99 213-16-6183 Md. Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Md. Baltimore Towson 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 West Rd. 21204 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 Ñ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify. 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Home maker Own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Rosinski Katie Sukovjak 19a. Intormant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Melvin S. Schaefer/son 406 Rockfleet Rd. Apt. 202 Timonium, Md. 21093 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 DI Burial 2 Cremetion 3 Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) 3/17/00 Stanislaus Cemetery Baltimore, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licenses 1050 York Rd. Towson, Md. 21204 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Final Deart Jailer disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or es a consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Wera autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy 1 🗆 Yes 2 No 1 ☐ Yes 2 No 25. Was case reterred to medical 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

The law requires that the death certificate be executed P.O. Box 68760, Records. Division of Vital or Attending Physician: **Physician**

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

28a-f

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If teen 27 is married offer any fillury or other traumetic event atols.

Physician /Medical

Examiner

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physician s the burial

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signed by

page 2 should

director,

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After

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Hospital

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filled in by

Examiner

Physician/Medical

Be Completed by

edical Certification: To

29a. Certifier (Check only one)

Saltimore, Maryland 21215-0020

DHMH 16 Rev 6/95

State Registrar

29b. Signature and title of certitier

29c. License number

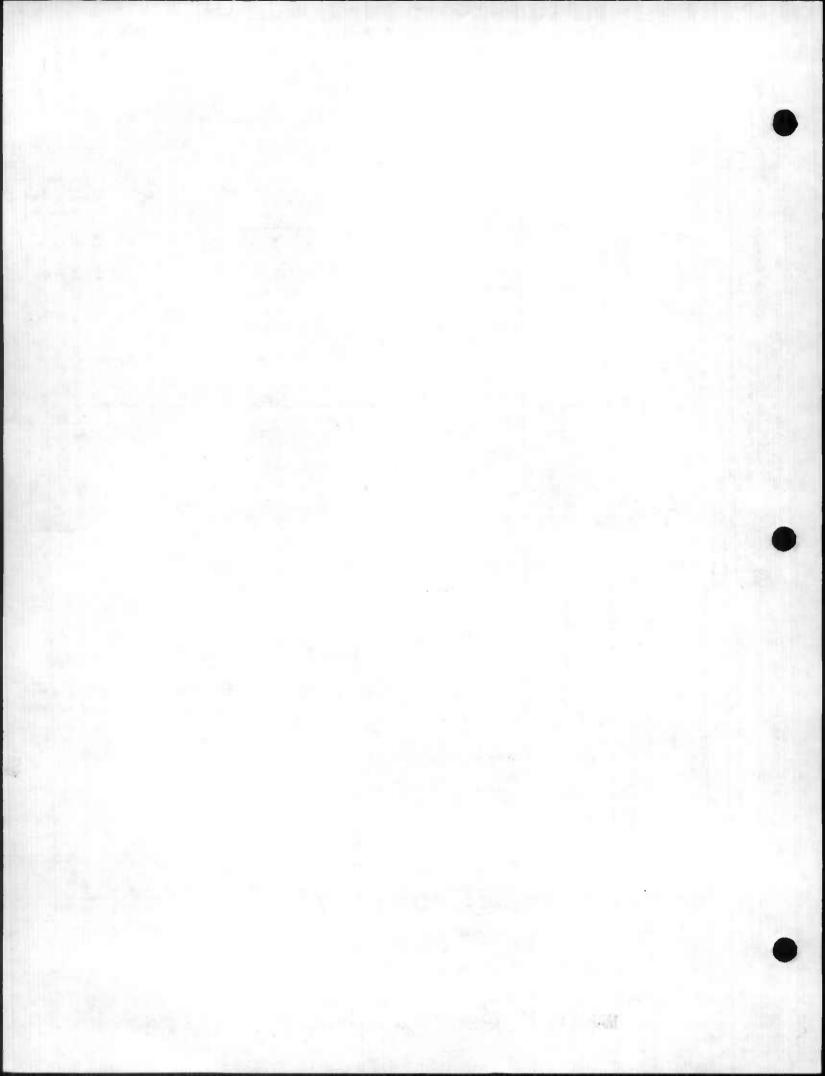
1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northern Parkway Honore

31. Dete filed (Month, Day, Year) 32. Registraria Signature

16



State of Maryland / Department of Health and Mental Hygiene 00 08832

					Ce	ertifica	e of	Death		Reg. No.	•	0006
Physician /Medical	1. Decedent's Name (First, Middla, Last) Willie M. Claud								2. Data of Dec Month MARCH	ath Day	Year	3. Time of Death
Examiner	4a Facility Nama (If not	Institution, giv	a street and numb	er)				4b. City, Town, or I	Location of Death	4c. Count	ty of Death	•
	SINAY HOSE							3AUTIMOR				
Funeral Director	5. Social Security Numb - 223-18-611		ex ØM 2□ F	Age (In yrs. 78	Vre	Months	Days	Hours Min.	8. Data of Birt (Month, Da		9. Birthp Cour	placa (Stata or Foraign htry) V a
2	Usual Residence of Dec											
ahov ahov		o. County	/ ^		y, Town or L timor						1	0d. Inside City Limits 1 ☑ Yas 2 ☐ No
Sector of Sector	Md 10e. Street and Number		/A	Dai	CTIIIOT		0-4-		10g. Citizen of What Country?			
020 urs after death with the Maryland air, or harm 23s or 28s-f show transfer. must be notified at by Funeral Director	3918 Wood		venue				1216	5	U S A			
	11. Marital Status		12. Was Decede Armed Force	ent Ever in U	S. 13.	Was Dece	dent of H	tispanic Origin? (S an, Mexican, Puart	Specify Yes or No- to Rican, atc.) 14. Raca - Al Black, W			
	1 Never Married 3 Widowed 4	Y\X\Yas 2 □ No If Yas, Giva Yaar or Datas:				Specify:			specify: Black			
15-002 72 hours "natural", edeal Ex	15.	Decedent's Ed	ucation 16a. Decedent's Usual Occupation (Give kind of work done during most					pation	kina	16b. Kind of I	Business/In	dustry
	Elementary/Secondar	y (0-12)	College (1-4	or 5+1N/A					A&P Warehouse			
Co series	47.5-0-4-11	N/A	11 - 1	Forklift Operator								
Be average	17. Father's Nama (Firs	i, Miodia, Liist)	UNK						ame (First, Middle, Maiden Sumama)			
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and 2 st saith and 27 is n	19a. Informant's Name/Relationship (Type, Print) Christina Claud - Wife 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, 3918 Woodhaven Avenue Baltimore, Md 21											
Baltimore, Maryland 212' pemit. Pages 1 and 2 should be filed withir Department of Health and Mental Hygiene. Important: if Item 27 is marked other than eny injury or other traumatic avent, the M page. To Be Compi	20a. Method of Disposition 1 \(\mathbb{D}\) Burial 2 \(\mathbb{C}\) Cramation 3 \(\mathbb{R}\) Removal from State 4 \(\mathbb{D}\) Donation 5 \(\mathbb{O}\) Other (Specify) 20b. Place of Disposition (Name of cematary, crematory or other place) King Memorial Park 20c. Location - Cit cematary, crematory or other place) Randallis											
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ion of Vital nding Physician: This.: After this certificate tuneral director, pa	27. Manner of Death	☐ Pending	28a. Data of I (Month,	njury Day Year)	28b. Tima Injury	of	28c. Injur Wor	ry at rk?	28d. Dascribe I	now injury occu	urred	
VISION Altending Altending Actor: Afte by the fune	2 Accident	investigation				М		Yas 2 □ No				
P Page P	3 Suicide 4 Homicide 6 Could not be determined 28a. Place of Injury - At homa, farm, streef, factory, office building, atc. (Specify) 28f. Location (Street and Number or Factory, office building, atc.)								nber or Run	al Routa Number,		
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Wilhin 2 within 2 comple	29b. Signature and title of certifier 29c. License number 29d. Data signed (Month,								Day, Year)			
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10	30. Narga and eddress of person who completed cause of death (Item 23a) (Type, Print)											
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SORP Land of Telesion sections of the control of the control of the

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Month **Physician** Virginia Lydia Dietz 2000 2:55 AM March 14 /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street and number) 4c. County of Death Examiner Genesis Eldercare Center Cromwell Parkville Baltimore 8. Data of Birth (Month, Day, Year) Aug. 13,1914 If Under 1 Yeer 5. Social Security Number 9. Birthplace (Stata or Foreign Country) Maryland 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Days Hours Yrs. Director 85 213-38-7034 Usual Rasidence of Decedant 10s. Stete 10b. County 10c. City. Town or Location 10d. Insida City Limits 1 Yas 2 No Maryland Harford Joppa Directo 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b United States "natural", or thems 23st 21085 14 Old Sound Road 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Giva Year or Datas: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status Black, Whita, atc. 1 Nevar Married 2 Merried Maryland 21215-0020 1 Yes 2 No Specify: þ White 3 Ø Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygians. ther then Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 8 Years 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) Be 1 and 2 should be h and Mental Is marked or Not Known Brucher Not Known 19a. Informent's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Department of Health a important: if Item 27 is any injury or other tra-Joppa, Maryland 14 Old Sound Road Kenneth R. Dietz (Son) Baltimore, 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Pages 1 1 Burial 2 Cramation 3 Removal from Stata Holly Hill Mem. Gdns. 3/17/2000 Middle River, MD 4 Donation 5/ Other (Specify) ral Service Licensee 22. Name and Addrass of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 0 7922 Wise Ave. Dundalk, Maryland Part. Entar tha disease, or complications the caused tha death. Do not entar the mode of dying, such as cardiac or raspiratory arrest, shock, or haart failura. List only ona cause on each lina. Approximate Interval Batween Onset and Deeth **Physician** HOURS PNEUMONIA. /Medical Immediete Causa (Finel disaasa or condition rasulting in deeth) Examiner Dua to (or as a consequence of): Examiner EPSLS. physician and s the burial-trans Sequentially fist conditions, if eny, leading to immadiata cause. Enter Underlying Cause (Disease or Injury that Initiated events rasulting in death) Last Dua to (or as a consequence of) Box 68760. the death certificate be Physician/Medical Dua to (or as a consequence of): USB 23b. Did tobacco use contribute to the cause of death? Part ff. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Pert f. P.O. 1 Yee 2 No 3 Probably 4 Unknown 3 signed b Records. by 24b. Wara autopsy findings available prior to 24a. Wes an autopsy performed? Completed peen completion of cause of death? 1 Yas 2 No Division of Vital Be 25. Was casa refarred to medical examinar? 26. Placa of Death (Check only ona) Other: 10 1 Yes 2 16 1 | Inpatient 2 | ER/Outpatient 3 | DOA Nursing Homa 5 Rasidance 6 Othar (Specify) this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? Certification: 1 Accidant Attending 5 Pending investigation o the Hospital or Attending thin 24 hours after death. The Funeral Director: After impletely filled in by the fun 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 ☐ Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.

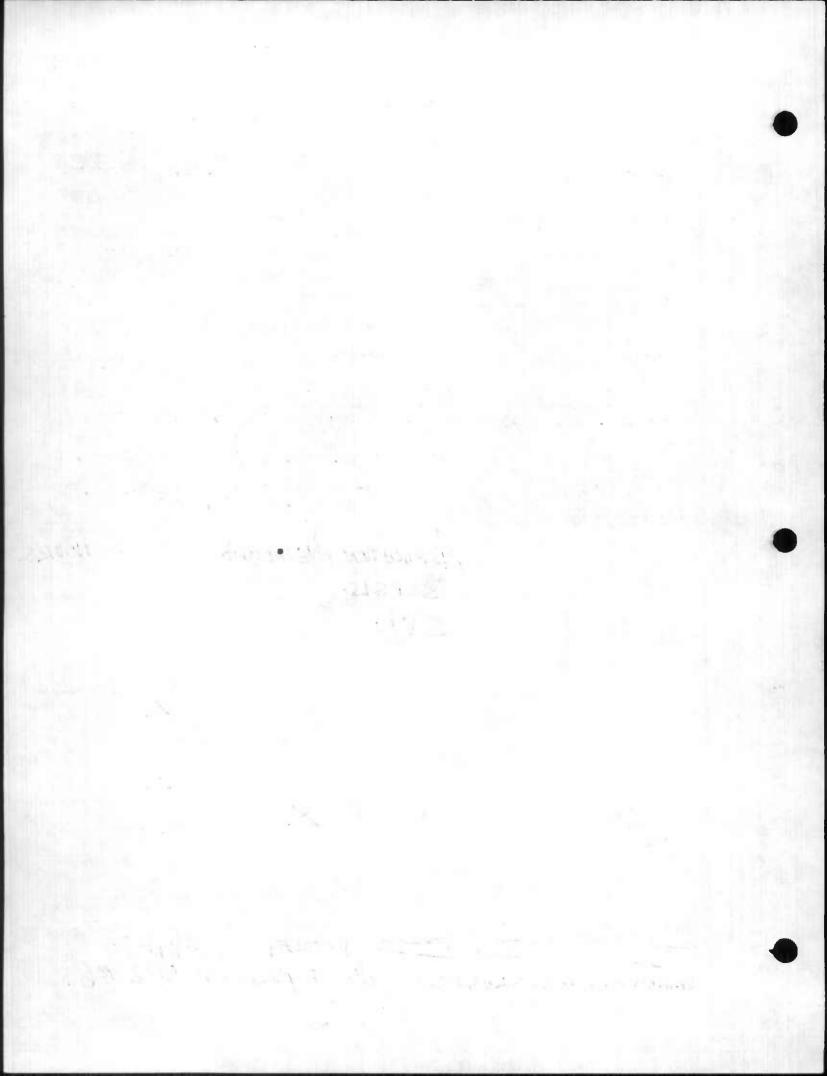
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at tha time, data end place, and due to the cause(s) and manner steted. 29a. Certifier Medicai (Check only one) To the I vithin 2 To the I complet 29b. Signature and title of earlife 29d. Data signed (Month, Day, Year) 29c. Licensa number phell BUD MD 212136. 30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

SRIRAM H. (SACASUBRAMANIAN) 32. Registrar's Signatura State Therenes

DHMH 16 Rev 6/95

Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08834 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2000 Bernard Jerome Deppe, Jr. March 15 5:40AM 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 7606 Far Hills Drive Baltimore Towson If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Ye Birthplace (State or Foreign Country) Davs Months 1⊠M 2□F 216-24-0047 Sept. 19 1928 Maryland Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MI. Baltimore Towson 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7606 Far Hills Drive 21286 LISA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Detes: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Maritel Status Black, White, etc. 1 Never Married 2 Merried 1 Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Printing Sales/ Forms Printing 18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Olga Catherine Fuhrmanneck Bernard Jerone Deppe, Sr. 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mr. Bernard Jerome Deppe III/ Son 1619 Hardwick Road Towson, MD. 21286 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donetion 5 □ Other (Specify) 3-20-00 Hilltop Service Co. Towson, MD. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, MD. 21204 21. Signeture of Funeral Service Licanse 23a. Part 1. Enter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final diseese or condition resulting in deeth) Due to (or as e consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or Injury Due to (or es a consequence of): thet initiated events resulting in death) Lest Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. No Yes 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yas 2 Ø No 1 ☐ Yes 20 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2€ No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28h Time of 28c. Injury at Work? 5 Pending 1 TYes 2 No investigetion 2 Accident 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 281. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner The law requires that the death certificate be executed burial-transit physician the bunal Box 68760, Physician/Medical 88 for use a signed by the a Division of Vital Records, P.O. þ Completed or Attanding Physicien: Be After this luneral

Physician

/Medical

Examiner

Funeral

Director

Examiner must be notified

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pemit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or item any injury or other traumatic event, the Medical Espaines

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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death

27. Manner of Death 1 Naturel

29e. Certifier

30. Name

(Check only one)

edical Certification: To s after death. filled in by within 24 hours a To the Funeral I completely 29b. Signature and title of certifier

State Registrar

To the Hospital

31. Date filed (Month

RMD 32. Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

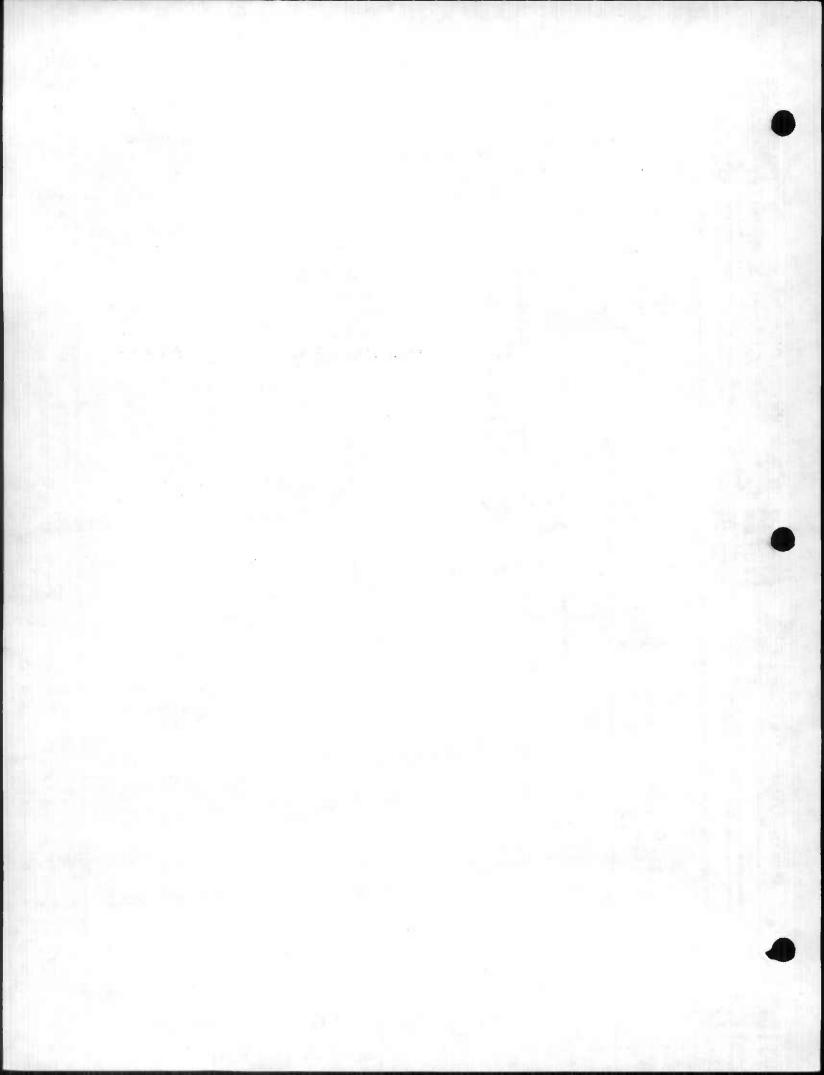
Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

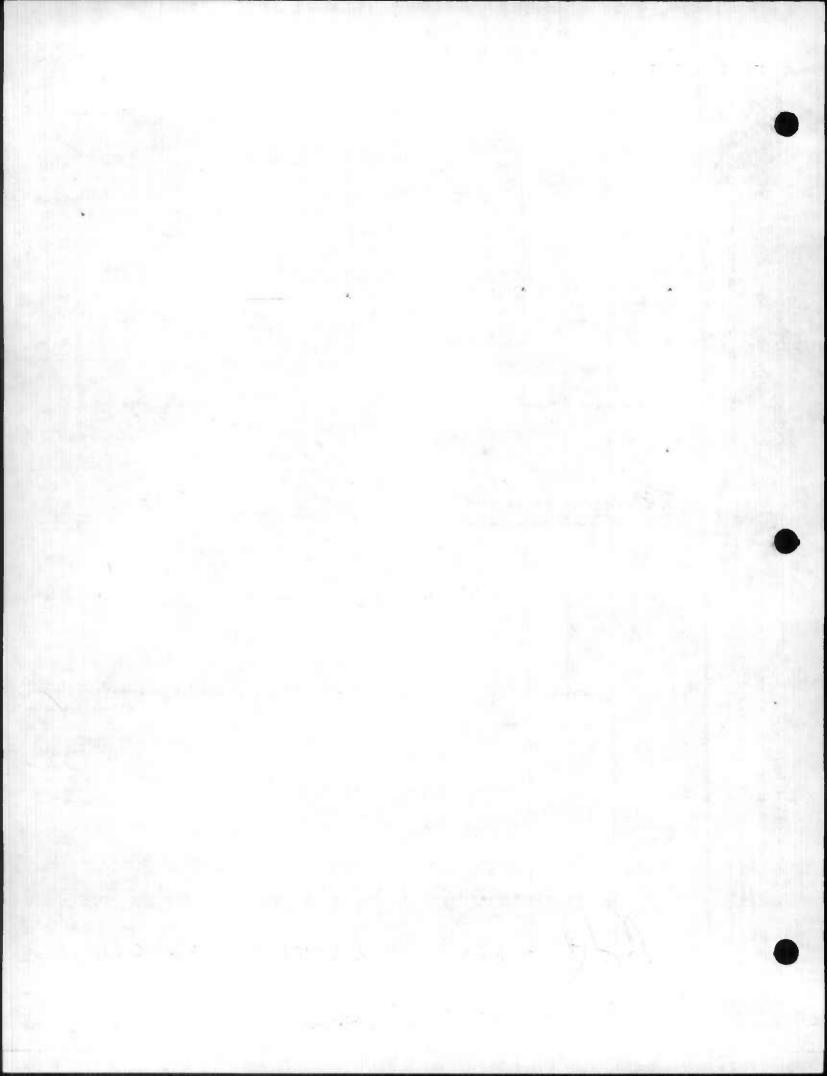
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29d. Date signed (Month, Day, Year)

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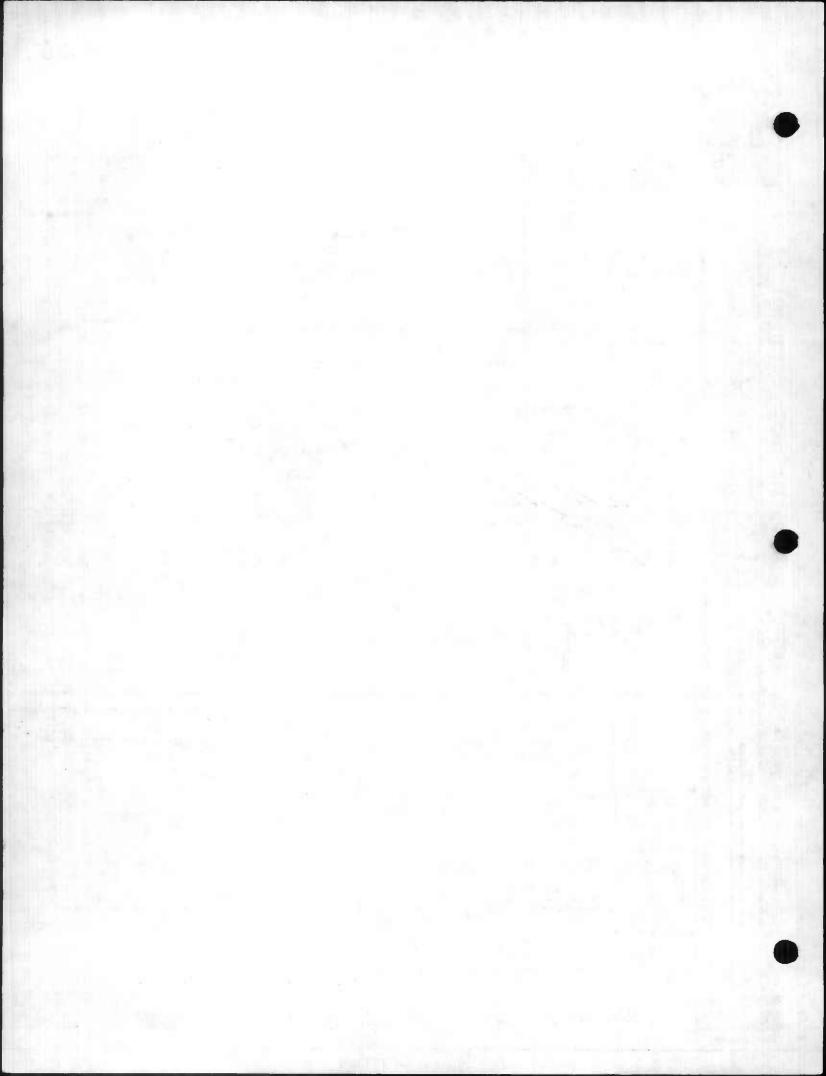
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Examiner	VAMHCS FORT HOWAR	DIVISION			FORT HOL	JARD	BATT	TMORE			
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Vrs. Months Days Hours Min. (Month, Day, Year) 9. B										
Director	215-16-0765 Usual Residence of Decedent	Marylar	nd								
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af at at stand	Maryland N/A	F	Baltimore					1.5	Yes 2 No		
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iner must	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U,S. 13. Wes	Decedent of s, specify Cut	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	- 14. Rad Blad	se - American Ind ck, White, etc.	en,		
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2	Anthony Denisiuk					growski					
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	Melvin L. Blizzar		b. Place of Dispositio	n (Neme of		Date Pe		D1a 1/35 City or Town, St			
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1	1 Heatyla	M. M.		05	0450	1	Marca	L. 12.	2000		
,	30. Name and address of person who o	ompleted cause of death	(Item 23a) (Type, Prin	1)	. 0			116	2000		
State	DR. ARAS O YA DA	NI, M.D C	600 NORTH	POINT	ROAD, FO	ORT HOWAR	D, MD 2	1052			



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	5. Social Security 216-56-	Number -3209	6. Sex 1∭MM 2□ F	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Y Months D	ear If Un ays Hou	der 24 Hrs. rs Min.	8. Dete of Bi (Month, D 12/30/	rth ev. Year)	9. Birth	nplace (Stete untry) ryland	or Foreign	
	Usuat Residence 10a. State	of Decedent		10c.	City, Town or Lo	ocation						10d. Inside (City Limits	
1	MD	Нат	ford	I A	bingtor				1 🗆 Yes	20X No				
	10e. Street and N	lumber 3ox 482	14		10f. Zip Code 21009					10g. Citizen	of What Co	untry?		
Completed by Fur		orried 2 Mer	Armed 1 Ye	2. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			3. Wes Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ☒ No Specify:				No- 14. Race - American Bleck, White, etc. Specify: White			
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	17. Father's Name						me (First, Middle, Maiden Sumeme)							
	Philip A					. Clauss								
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edicai Examiner	disease or condition resulting in death) Due to (or es a consequence of): Due to (or es e consequence of): if any, leading to immediate cause. Enter Underlying								1					
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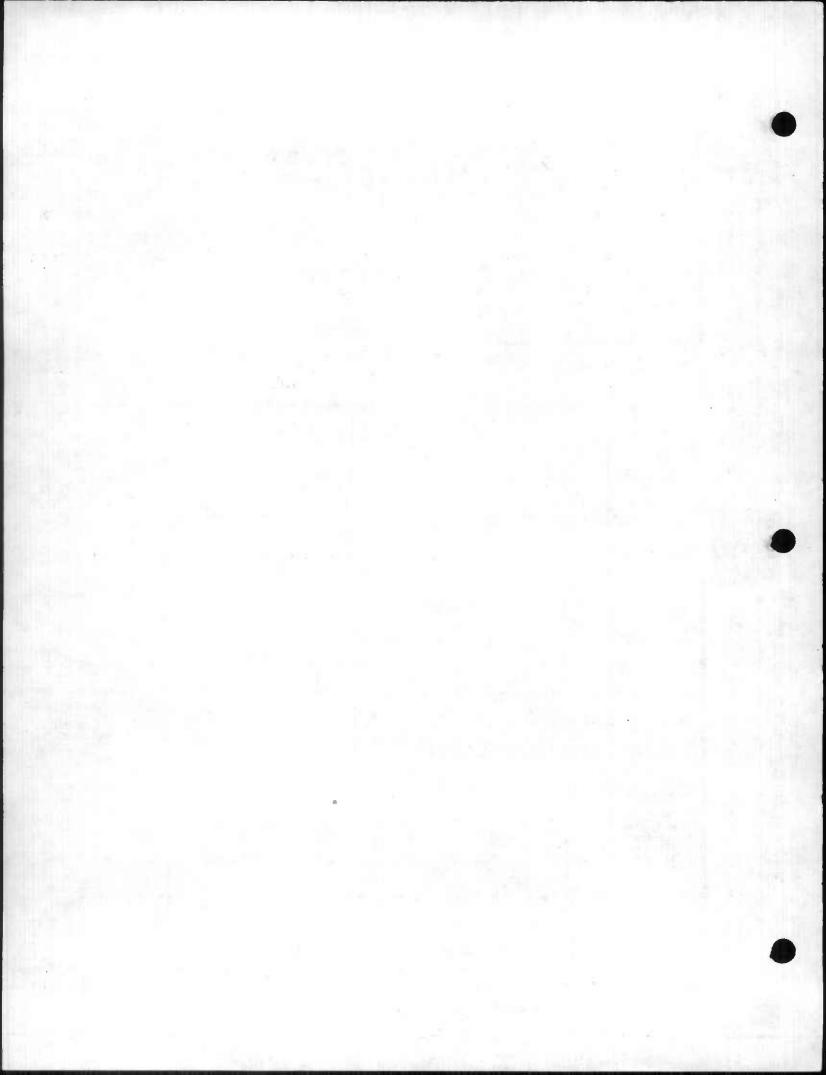
ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Dev Month Year **Physician** JAMES JOSEPH 4:50 PM 14 2000 MARCH /Medical 4a Fecility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE HAR BOR CENTER If Under 1 Yaar If Undar 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Deys Hours Yrs. 216-30-8182 65 Director 27,1934 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits shons 1 ☐ Yas 2 No Md Baltimore Dundalk Directo 28a-f must be notifi 10e. Street and Number 10f Zin Code 10g, Citizen of Whet Country? 'natural', or hams 23s or 3 Oakwood Rd. AptB 21222 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - Amarican Indian, 11 Merital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Bleck, White, etc. filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0020 Specify: White ğ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Truck Driver self employed 7 yrs. 17. Father's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be file.
Department of Health and Merial Hy.
Important: if Item 27 is marked offs, sky injury or other traumatic event addiså James Joseph Finn Dorothy B. Wirth 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) Virginia Finn wife 3 Oakwood Rd. Apt B. Dundalk, Md. 21222 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Mar 18 20a. Method of Disposition 20c. Location - City or Town, State Buriat 2 Cremetion 3 Removel from State Holy Rosary 4 □ Donetion 5 □ Other (Specify) 2000 Md. Dundalk 21. Signature of Funeral Service Licenses 22. Name end Address of Fecility Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222 23a. Part): Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediete Cause (Finel disease or condition resulting in death) LUNG CANCER METASTATIC 6 MONTHS Examiner Examiner physician and the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Toe 2 No 3 Probably 4 Unknown CORONARY ARTERY DESEASE by 24b. Were autopsy findings aveilable prior to completion of causa of deeth? 24a. Wes en autopsy performed? Completed DIABETES MELLITUS 1 Yes , 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cardifict completely filled in by the funeral director, 89 25. Was case referred to medical 26. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) end manner steted. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 29c. License number MARCH 14, 2000 SOUTH HANDVER STREET 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) PANDEY KUMAR HARBOR BALTIMORE, MD HEMANT HOSPITAL CENTER 32. Registrer's Signeture 31. Data filed (Month, Day, Year) State MAR 1 6 2000 Registrar

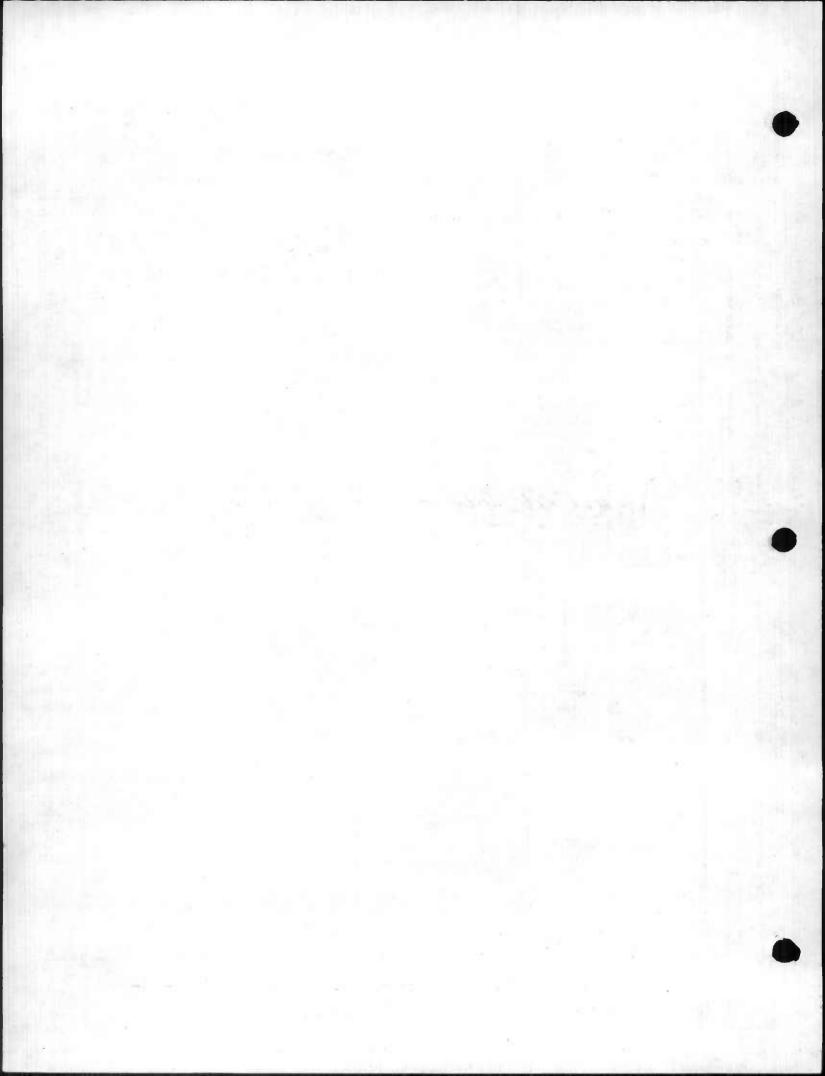


		1. Decedent's Nen	ne (First, Middle, La	st)							2. Date of D		.,	3. Time of Death	
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	Funeral	5. Social Security i	last birthday) If Under 1 Year If Under 2 Months Devs Hours				der 24 Hrs. 8. Date of Birth (Month, Day, Year)			Birthplace (State or Foreign Country)					
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	tor death with the Maryla litems 23e or 28e-f short free must be notified at furneral Director	10e. Street and Nu	mber Main Str	eet			10f. Zip Code 21713					10g. Citizen of Whet Country? USA			
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21215-0020	ed within 72 ho ygiene. wr then 'naturn t, the Medical J Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)					16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)				ng	g			
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Baltimore,	Pages 1 a nard of Hea nt: If Illem iry or othe	20a. Method of Dis 1 ☐ Burial 2	Place of Disposition (Name of semalary, cremetory or other place)					Date 20c. Location - City or Town, St			Fown, Stete				
Balti	Departit Departit Importar any Inju	4 M Donetion 5 Other (Specify) 21. Supering Control Service Licensee Royald S. Wade Director 22. Name end Address of Fecility State Anatomy Board 655 W. Baltimore, MD 21201										timor	e Street		
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Division of Vital	Attending Ph or death. ector: After th by the funeral iffication: 7	27. Manufer of Deel	th 5 Pending Investigation	28a. Date of (Month,	Injury Day Year)	28b. Time of Injury	of 20	8c. Inju Wo		- 1		how injury occu			
Divis	tal or Attending P rs after death. al Director: After t led in by the funers Certification:	3 Suicide 4 Homicida	6 Could not be datarmined	28a. Place or building	28a. Place of Injury - At home, Ierm, street, lectory, office building, atc. (Specify)					d	28I. Location City or To	(Street end Num own, Stata)	nber or Ru	iral Routa Number,	
	To the Hopital or Atending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	29e. Certifier (Check only one)	Certifying Ph 2 Medical Exam	yaician: To the be niner: On the bas and manna	is of examinat	wledge, deel tion and/or in	th occurred anvestigation,	nt the ti	ma, data and opinion, deat	d place, e	end due to the	e cause(s) and n	nanner as , and dua	stated. to the cause(s)	
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		30. Name and address of person who completed ceuse of deeth (Item 23a) (Type, Print)													
		Dr. Glor	ia Pura 3	66 Mill	Street	, Hage	erstow	m,	Maryla	and a	21740/	301-791	-690	0	
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	Registrar		MAKID	2000	Jan Jan	/	v . 14	4004	RS						

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene

08838



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death GRIFFIN **Physician** MARCH CARMEN DELORES 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not Institution, giva street and number) 4c. County of Death Examiner BALTIMORE HOSPITAL RANDALISTOUN NORTHWEST 7. Age (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1DM 2DF 218-30-7409 February16,1936 Director Usual Rasidance of Dacedani 10a. Stata 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at 1 ☐ Yas 2 No Funeral Director Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 Caraway Rd., Apt 3B 21136 USA 12. Wes Decadant Evar in U,S. Armed Forces? 1 Yas 2 No If Yas, Giva 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) the Medical Examiner in 11. Meritel Status 14. Race - American Indian, Black, White, etc. 1 Nevar Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specity: by 3 ☐ Widowed 4 ☐ Divorced White Yaar or Datas: Completed 15. Decedant's Education (Specify only highast grada completed) 16a. Decedant's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working lifa. DO NOT use retired) Elemantary/Secondary (0-12) Collaga (1-4or 5+) 10 Manager Restaurant 17. Father's Name (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) permit. Pages 1 and 2 should be libestment of Health and Mental Important: If New 27 is marked or any Injury or other traumatic eve Lawrence Gordon Carmen Gordon 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Patrick Reed Son 2930 Schoolhouse Rd., Finksburg, MD 21048 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Othar (Specify) Carroll Cremation 3/17/00 Hamstead, MD 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility 11824 Reisterstown Rd Kon Eline Funeral Home Reisterstown, MD 21136 23a. Pert1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, of heart failure. List only one cause on each line. Physician SEPSIS Immediata Causa (Final diseasa or condition resulting in death) /Medical Examiner Dua to (or as a consequence of): by Physician/Medical Examiner PNEUMONIA Sequantially list conditions, if any, leading to immadiate cause. Entar Undarlying Cause (Disaase or injury that initiated avents rasulting in deeth) Last The law requires that the death certificate be execu ADENO CARCINOMA METASTATIC UMKNOWN PRIMARY Part II. Other significant conditions contributing to deeth but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Certification: To Be Completed 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No or Attending Physician: 25. Was casa rafarred to medical axaminer? 26. Place of Death (Check only one) 1 Yas 2 No Hospital: 1 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) this To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral 28a. Data of Injury (Month, Day Year) 27. Mannar of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending invastigation 1 Aatural 1 Yas 2 No 2 T Accident 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number City or Town, Stata) 28a. Place of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homlcida

Division of Vital Records, P.O. Box 68760,

State Registrar 29a. Cartifian (Check only one)

29b. Signatura and titla of cartifiar

31. Data filed (Month, Day, Year) MAR 1 6 2000

12 AVI

MD, NHC 32. Redistrar's Signatura Denevas

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

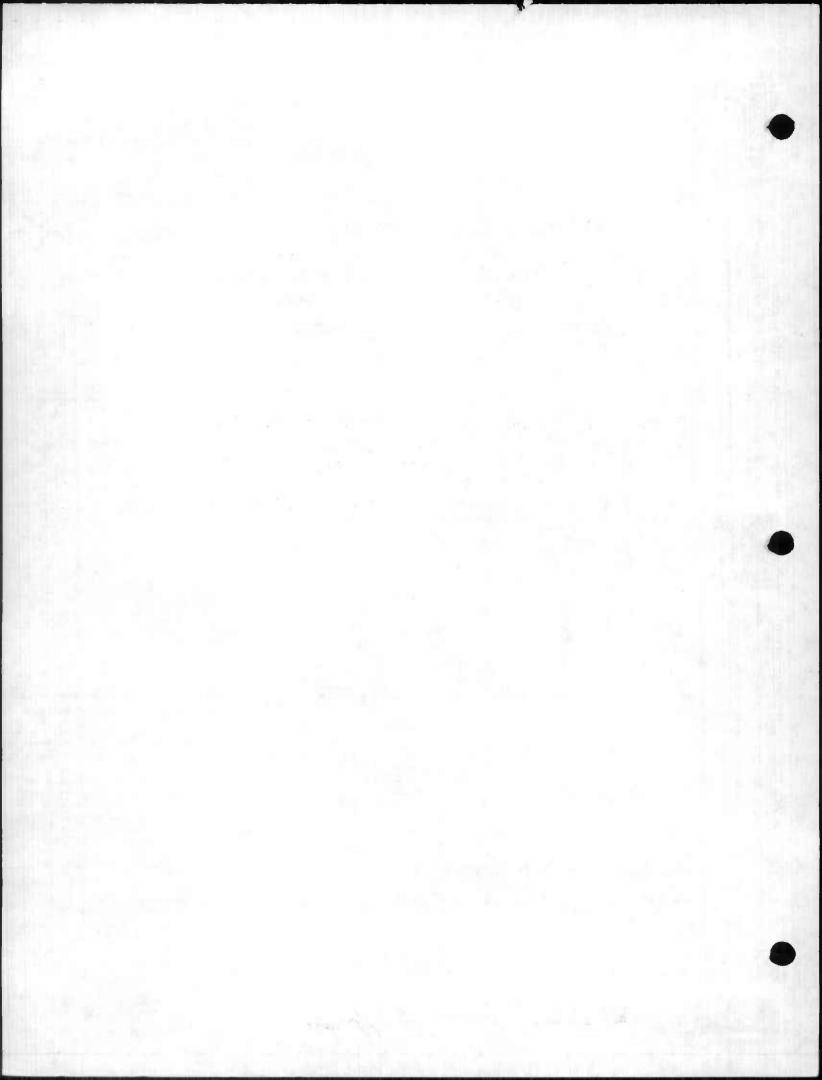
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Data signed (Month, Day, Year)

MARCH 14, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08840 Certificate of Death AMENDED TTEM #1 PER MD G781 3/16/2000

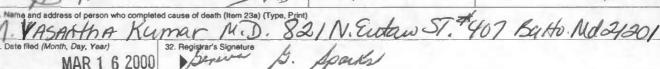
1. Decedent's Name (First, Middle, Last) AGNES AH HAGGANS 2. Date of Death 3. Time of Death Month Year **Physician** 07.45 PM 2,000 MARCH 13 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore N/A OCKGLEN NURSING HOME If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 10 M 2 F 9-3-1917 Director Md 212-12-6344 Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow Examiner must be nothlied at N/A 1 Yes 2 □ No Director Md Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 238 10 N. Rock Glen Road USA 21229 Funeral Reme 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental hygiene.
Important If item 27 ia marked other than "natural", or feel may injury to other traumatic event, the Medical Examples 1 Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: specify: Black by 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Various Jobs Elementary/Secondery (0-12) College (1-4or 5+) 9th grade N/A Laborer 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 10 Mary Louise Royal Henry Clay Hunt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4718 Wakefield Road Darlene Howard- Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date XBurial 2 Cremetion 3 Removal from State King Memorial Park 3-17-00 Randallstown, Md 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Piperal Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Avenue Baltimore, Md 21215 26a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on a failure. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final PNEUMONIA DAYS disease or condition resulting in death) **Examiner** Physician/Medical Examiner TUMOR BIOPSY REFUSED MONTHS requires that the death certificate be axecuted lcian and burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last physician s the burial 68760 Due to (or as a consequence of): Box (Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by the 3 Probably 4 ☐ Unknown 1 Yes 2 No Records. Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? page 2 1 Yes 2 HNo 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Metural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicida 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) á 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiar tely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the To the To the F

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State Registrar

31. Date filed (Month, Day, Year) MAR 1 6 2000

29b. Signature and title of certifier

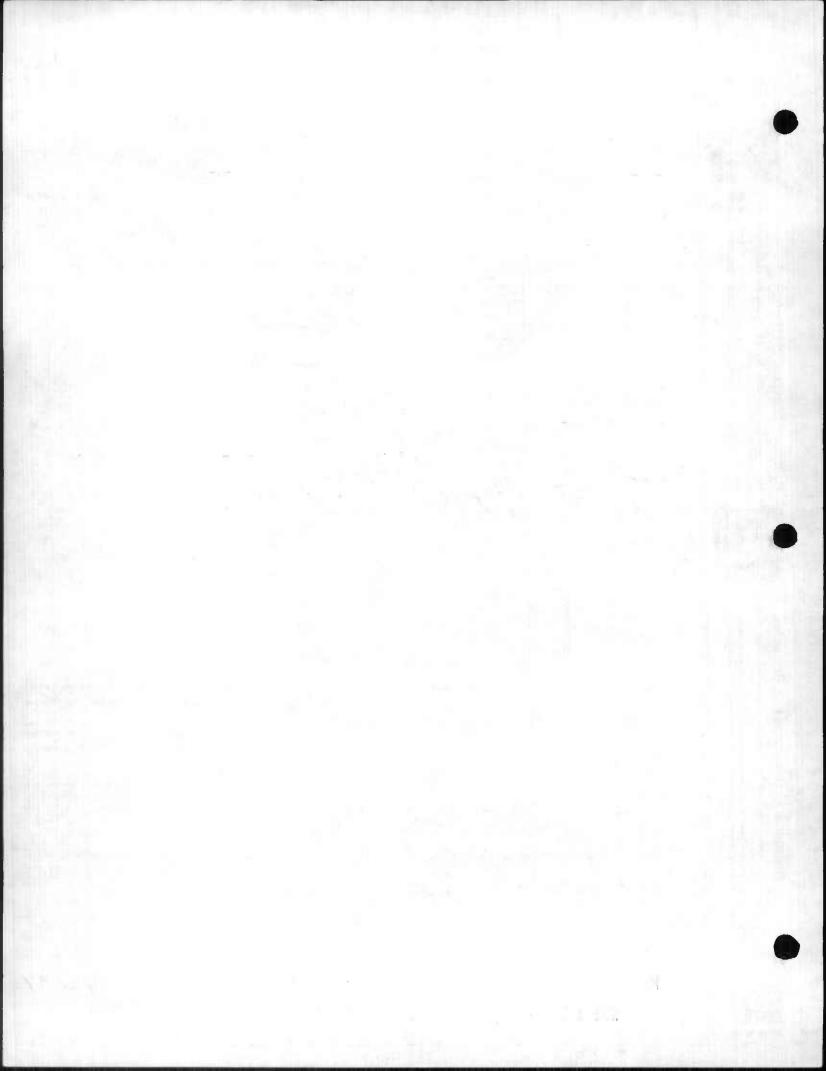


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29c. License number

29d. Date signed (Month, Day, Year)

MARCH 13TH 2000



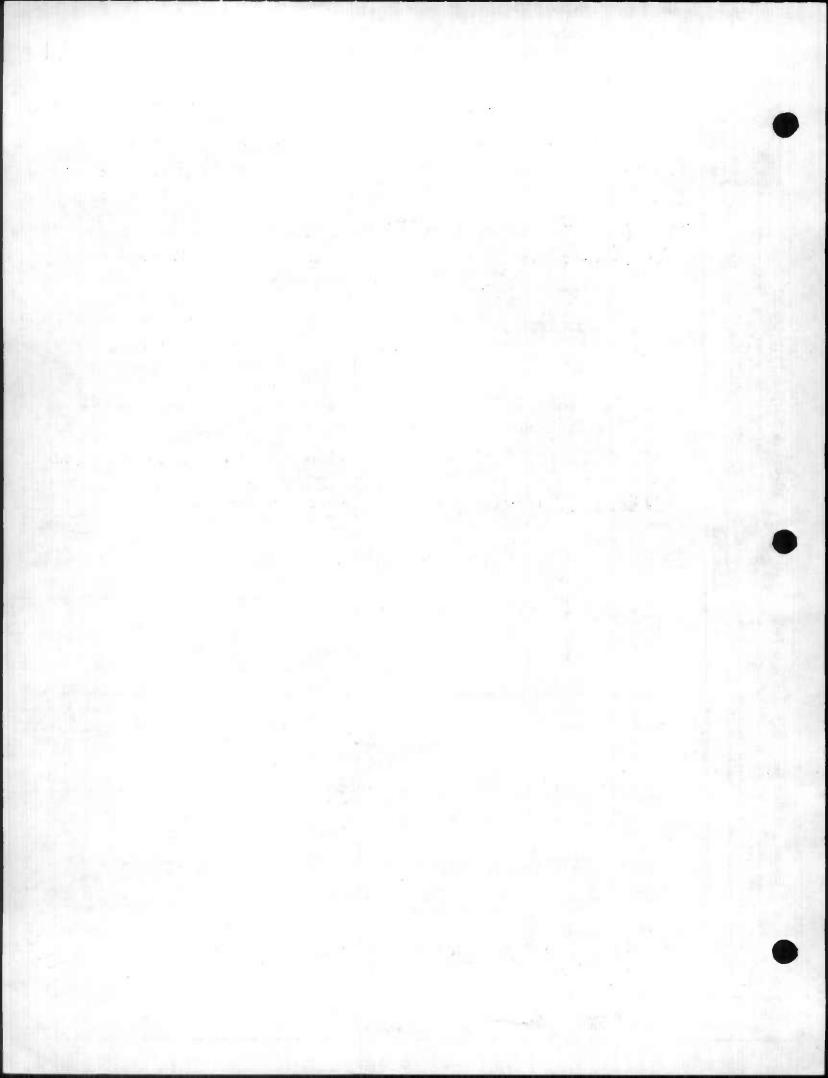
State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Agnes Teresa Harkum March 13, 2000 12:30 PM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Ridgeway Manor Nursing Home Catonsville Baltimore | Months | Days | Hours | Min. | July 11,1916 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** 10 M 20 F 83 Yrs. 212-09-4729 Director Maryland Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or flams 23s or 28s-f sho the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21230 Funeral 800 S. Sharp Street 12. Was Decedenf Evar in U.S. Armed Forces? 1 ☐ Yas 2 전 No If Yas, Giva Yaar or Datas: Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, White, atc. 72 hours after 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be flied within Department of Health and Mental Hygiers. Important, if flem 27 is marked other than ", any injury or other traumeds event the Manager Statement of the Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Fethar's Nama (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be Wilamena Miller Martin Hittel 2 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 800 S. Sharp Street Baltimore, Maryland 21230 Roland R. Harkum (Son) 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata ty⊟Burial 2 ☐ Cramation 3 ☐ Ramovel from Stafa 4 ☐ Donetion 5 ☐ Other (Spet New Cathedral Cemetery 3/17/00 Baltimore, Maryland 21. Signature of Funarel Sarvice Lie 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, Maryland 21227 acaused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, on each line. 23a. Pert1. Enfer the diseesa, or complications shock, or haart failure. List only ona Approximate Interval Batween Onset end Death **Physician** /Medical Immedieta Cause (Final diseasa or condition resulting in death) 0 Examiner Dua to (or as a consequence of) Examine sician and burial-transit Sequentially list conditions, if any, leading to immadiate cause. Enter Undarlying Cause (Diseese or Injury that initieted events rasulting in death) Last Dua to (or as a consequence of): physician s the burial Records. P.O. Box 68760 edical Due to (or as a consequence of) Physician/M been signed by the atte should be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacço use contribute to the cause of death? 22 No 3 Probably 4 Unknown 1 Yss by 24b. Were autopsy findings available prior to Completed 24a. Wes an eutopsy performed? completion of cause of death? 2/2 No 1 ☐ Yes 2 No certificate 1 ☐ Yes Division of Vital director. Be 25. Was case rafarred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4⊠ Nursing Homa 5 ☐ Rasidence 6 ☐ Othar (Specify) 2 1 Yas 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Death 28d. Describe how injury occurred Certification: 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? After Attending 1 Netural 5 Panding invastigation To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to tha causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to tha causa(s) and manner stated. edicai 29b. Signature and title of certifial 29c. License number 29d. Data signed (Month, Day, Year) 00 cause of death (Item 23a) (Type, Print) # 203 Balx NE 716 Marden Month, Day, Year) 32. Regisfrar's Signatura State

DHMH 16 Rev 6/95

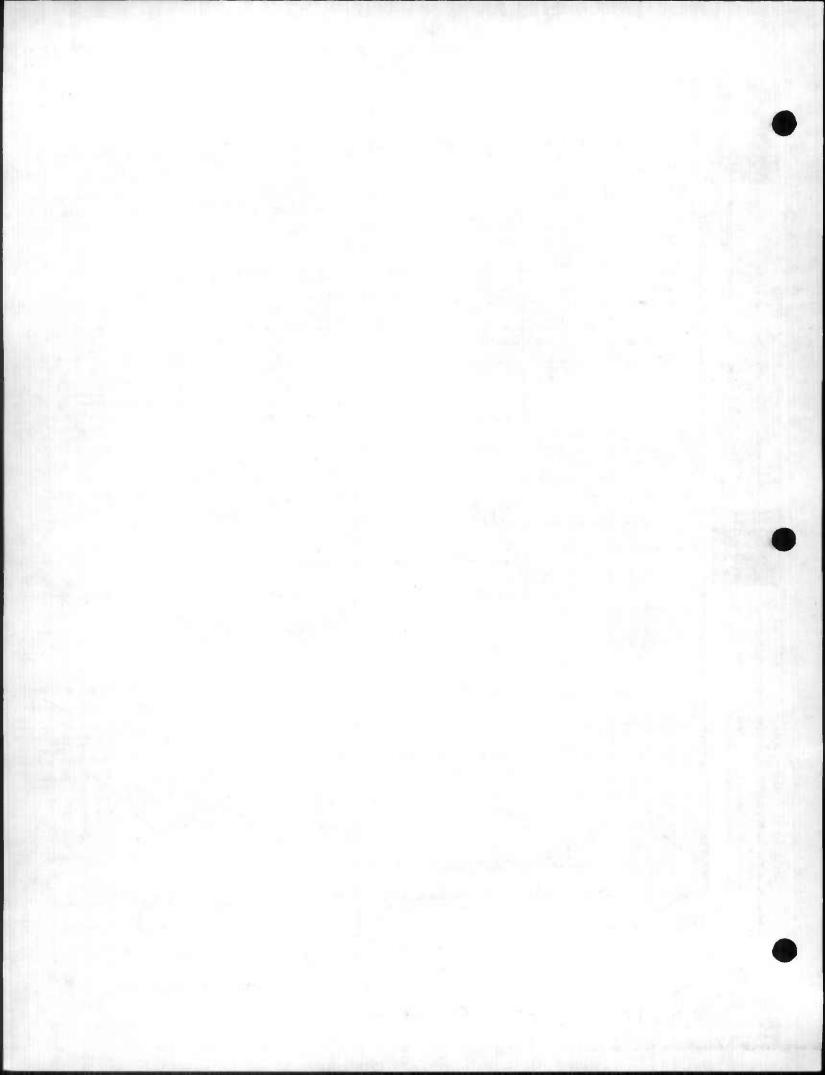
Registrar

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State of Maryland / Department of Health and Mental Hygiene 00 08842.

			C	ertificate of	Death		Reg. No.		00046			
	cedent's Name (First, Middle,	Last)				2. Date of De		Vees	3. Time of Death			
sician	atherin	14.		Tone	5	Mancel	Day 13 ~	Year 2000	835AM			
edical 4a Fac	clity Name (If not Institution,	giva street and number	11/	1		Location of Deal	th 4c. County	1000	0			
	weesity of	Massland/	Medical	Sichem	BALF	mral	n/a					
			(In yrs. lest birthd	ley! If Under 1 Year	If Under 24 H	rs. 8. Date of Bi	rth	9. Birthple	ace (Stata or Foreign			
218	3-36-5165	1□ M SSF 6	1 Yrs	Months Days	Hours Mi	in. (Month, Di		Md.	γ)			
Usual	INOV.	1930	rici.									
10a. S	State 10b. County		10c. City, Town o					10	d. Inside City Limits			
Md.		n/a		B	altimore				1 Domes 2 No			
10a S	itreet and Number			10f. Zip Code			10g. Citizen of	What County	n/2			
-	32 McCulloh S	treet			1217		USA					
0			- 110			10 - 11 - 11	14 000	ce - American Indien,				
	arital Status	12. Was Decedent Ev Armed Forces?	ver in U,S.	 Was Decedent of If Yas, specify Cu 	ban, Mexican, Pu	(Specify Yes of No arto Rican, etc.)	Bia	ck, White, e				
	Never Married 2 Marrie	If Yes, Give		1□ Yes 2□ No	Specify:		Specif	Bla	ck			
3 5	Widowed 4 □ Divorced	Year or Datas:		AA				DIG				
	15. Decedent's (Specify only highast	s Education grade completed)	16a. De	ecedent's Usual Occu	upation a during most of w	vorking	16b. Kind of B	usiness/Indu	ustry			
Elen	mentary/Secondary (0-12)	College (1-4or 5+)	ive kind of work done e. DO NOT use retire		1	D- 34	011 - 5131 - 61				
	th Grade		Teac	ner Assi	stant			-	Public Schoo			
	ther's Name (First, Middle, L					lame (First, Middle	, Maiden Sumer	ne)				
Edv	ward Armstron	g			Kathryn	Bodley						
19a. Ir	nformant's Name/Relationsh	ip (Type, Print)	19b. M	lailing Address (Stree	et and Number or	Rurel Route Numb	er, City or Town	Stete, Zip (Code)			
Day	vid Jones	son	3 M	learock Co	urt Owin	gs Mills	, Md. 21	117				
20a. M	lethod of Disposition			sposition (Name of cremetory or other pl		Data	20c. Location		vn, Stata			
15	Buriai 2 Cramation					12-						
4 Donation 5 Other (Specify) Arbutus Memorial Park March 17 Baltimore, Md.												
21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Nutter Funeral Homes, Inc.												
2501 Gwynns Falls PKWY Baltimore, Md. 21216												
23a. Part 1. Enter the disease, or complications that charged the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate												
shock, or heart leilure. List only one cause on the leilure in the death. Do not enter the mode of dying, socials cardiac or respiratory arrest, interval Between Onset and Death												
Immediate Cause (Final M //)												
disease or condition resulting in death) a. Muftiphe organ tailing to death)												
Due to (or as a organization of):												
- LOROMARY ARTERY BY MASS												
Sequentially list conditions, if any leading to immediate												
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Coronary Archery 5y press Due to (or as a consequence of): Coronary Archery 5y press Due to (or as a consequence of):												
that in	itiated events ing in death) Last	V	ua to (or as a con	sequence of):				i				
11.00								1				
		d				1						
Part II	Other significant condition	s contributing to death but	not resulting in th	e underlying cause o	iven in Part I	23h. Did	23b. Did tobacco use contribute to the cause of dear					
					and the second second		Yes 2 No	3 ☐ Prob				
						_	108 2LINO	3 - P100	- STORRIOWI			
						24e Wes	an autopsy	24b Wei	re autopsy findings			
						perf	ormed?	ava	iiable prior to			
								of d	eath?			
						1/8	Yes 2□No	1 🗆	Yes 2□ No			
25. Wa	as case referred to medical				26. Place of D	Peath (Check only	one)					
	aminer? ∃Yes 2⊟ No	Hospital:	2 ER/Outpa	ntient 3 DOA	ther:	Home 5□ Res		er (Specific)			
	inner of Death	28a. Date of Injury (Month, Dey		e of 28c. Inju			how injury occur					
1)	Natural 5 ☐ Pending		Year) Inju		ork? ☐ Yes 2 ☐ No							
	Suicide 6 Could no	ot be	u - At home for-			28f Location	(Street and Numi	her or Purel	Route Number			
	Homicide determin	28e. Placa of Injury building, etc.	City or To	wn, Stete)	Jei Ji Murel	risule realizer,						
	/	1										
29a. C		Physician: To the best of	my knowledge, de	eath occurred at the t	time, date and pla	ca, and due to the	cause(s) and m	anner as sta	ited.			
	one)	and mannar state	d.	vooligotion, arring	Opinion, death oc	Control of this filling	, Julio and place,	2112 000 10	62.000(3)			
29b. S	ignaluse and title of certiliar		29d. Data signe	d (Month, D	Pay, Year)							
	(- /	1487		March	14	2000						
20. 10	me and address of	h completed several tra	th (top 00+) (T	no Brint'	-/0/		·	17 1	2000			
SU. NAI	me and address of parson w	20	itti (item 23a) (Ty	2000 = 51	- and D	11.	11.1		.001			
21.0		ner LL	Mush 6A	evene of	ecer Bo	HIMORS	" Weyli	12	1001			
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rar ML	IR 1 6 2000	Benevas 1	J. pp	als								



State of Maryland / Department of Health and Mental Hygiene Certificate of Death

08843

1505 PM

t♥ Yes 2 No

	1. De
Physician	
/Medical	

CHARLIE JEFFRESS

Examiner

Director

Director r than "natural", or hams 23s or 28s-f the Medical Examiner must be notifie 72 hours after Completed filed within 7 Hygiens. other than "n permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if flem 27 is marked oths any injury or other traumatic event, pages. Be 10

Baltimore, Maryland 21215-0020

Funeral

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Physician /Medical Examiner

Examine physician and the burial-transit that the death certificate be assouted Box 68760. Physician/Medical for use as 680 Records, P.O. signed by I by s ueed should Completed Division of Vital 8 10 this : After this funaral of Certification: or Attending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun

ecedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 28, 2000 Charlie Jeffress FEB. 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 116 NORTH PACA STREET APT. #213 BALTIMORE | Window 24 Hrs. | 8. Dele of Birth (Month, Day, Year) | Min. | March | 12, 1937 5. Social Security Number If Under 1 Year Birthplaca (State or Foreign Country)
 Unknown 7. Age (In yrs. last birthday) Months Deys 10 M 20 F 62 219-46-0719 Yrs. Usual Residence of Deceden 10s. State 10b Counts 10c. City. Town or Location 10d. Inside City Limits MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 116 N. Paca Street 21201 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Bleck, White, etc. 1 Never Married 2 ☐ Merried 1 ☐ Yes 2 Ē No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Unemployed Unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown 19a, Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Ejimakor/Social Worker 116 N. Paca Street Baltimore, Maryland 21201
Dete 20c. Location - City or Town, Stele 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removel from Stete Gardens of Faith 3/15/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility John C. Miller Inc. 21. Signature of Europrat Service Licensee 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or confident on thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one double on each line. Approximete Intervel Between Onset and Deeth Immediete Cause (Finel disease or condition resulting in death) v= Vo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequença of) Due to (or es a consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yas 2 No 3 Probably Unknown Diabetes Mellitus 24a. Was an autopsy performed? 24b. Were eutopsy lindings available prior to completion of cause of death? INSPECTION 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? 26. Placa of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) XXYes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation

Registrar

Medical

31. Date filed (Month, Day, Year) State MAR 1 6 2000

2 ☐ Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 Could not be determined

41

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

RON LOUCE, 111 Penn Street, Baltimore, Maryland 21201 MO 32 Registrer's Signature

28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the tima, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted.

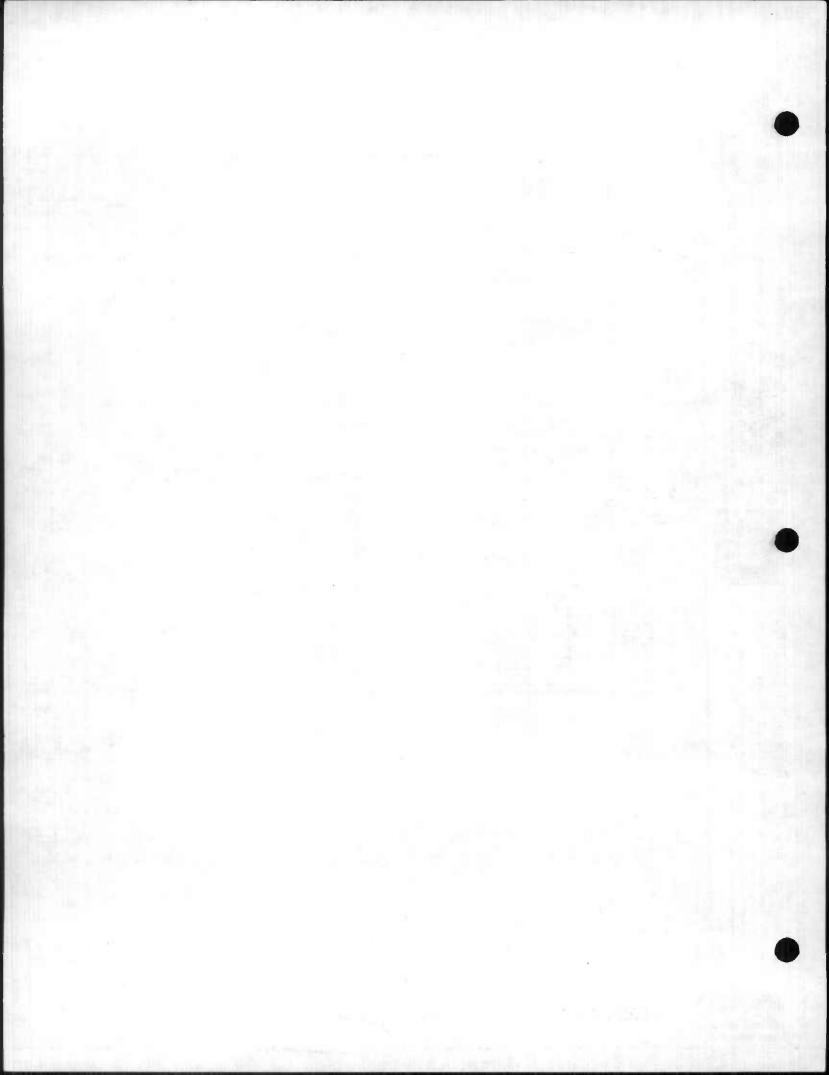
29c. License number O.C.M.E

1 Yes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MARCH 14, 2000



State of Maryland / Department of Health and Mental Hygiene 08844 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dey Month Year **Physician** Angie Knight March 15 2000 9:30 am /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare Heritage Center Dundalk Baltimore 8. Date of Birth (Month, Day, Year) Tune 5, 1909 7. Age (In yrs. last birthday) If Under 1 Year Months Days If Under 24 Hrs. 6. Sex Birthplaca (State or Foreign Country) Funeral Days 1 M 2 F Hours 213-20-2136 90 Director Va Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Ineide City Limits 1 ☐ Yes 2 No Md. Baltimore Edgemere Director 288-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? mant be a 2216 Lodge Farm Rd. 21219 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Meritel Stetus Black, White, etc. Pages 1 and 2 should be filed within 72 hours after near of Health and Mental Hygiene.

Int. If New 37 is marked other than "natural", or its ary or other traumatic event, the Medical Examins 1 ☐ Yes 2 No 1 Never Merried 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: White p 3 Widowed 4 □ Divorced Year or Detes: Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Matron Steel 6 yrs. altimore, Maryland 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Kurt Shiffett Icy Shiflet 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Audrey Leamer 2216 Lodge Farm Rd. Edgemere, Md. 21219 niece 20b. Place of Disposition (Name of cemetery, crematory or other plece)
Church of the 20e. Method of Disposition 20c. Location - City or Town, Stete Mar 20 Burial 2 Cremetion 3 Removal from Stete Department of Important: If any Injury or 4 □ Donetion 5 □ Other (Specify) Dyke, Va. Evergreen 2000 22. Name and Address of Facility
Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Rd. Dundalk, Md. 21222 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shown or heart facture. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician /Medical Immediate Cause (Finel ALZHEIMER'S DEMENTIX diseese or condition resulting in deeth) Examiner Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last and Due to (or es e consequence of): Box 68760. Physician/Medical the Due to (or es e consequence of): 980 Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? CHRONTE 1 Yee 2 No 3 □ Probably 4 □ Unknown RENAL FAILURE signed t Division of Vitai Records, þ Hypotty ROIDISM. 24b. Were autopsy findings avellable prior to completion of cause of death? Completed 24a. Wes an eutopsy performed? 1 Yes 2 No 1 Yes 20 No certificate Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Neturel To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun 1 TYes 2 No 2 ☐ Accident 6 Could not be 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end manner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D17753 K1/ 3. 16000 hammyne, aus-30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. C. D. HAR. M. A. C. F.N.R., M.D., 7/0 CHURCH ST. RALTIMORE, MD 2/225

DHMH 16 Rev 6/95

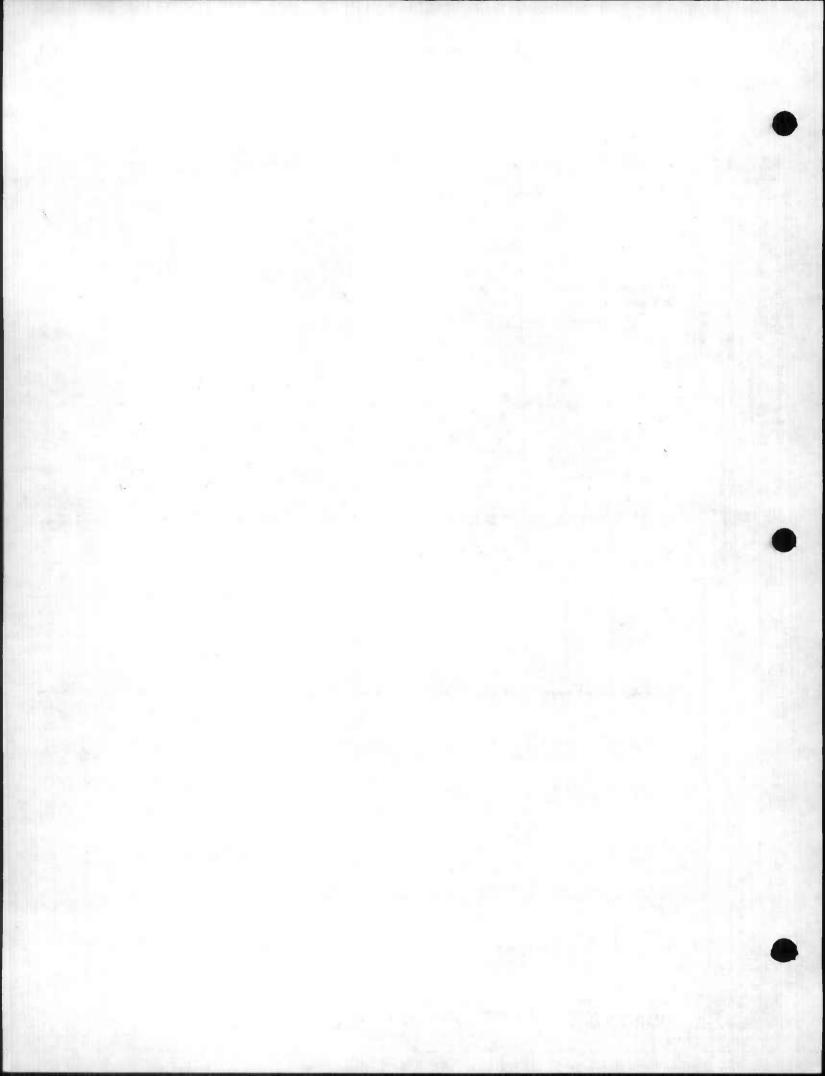
State

Registrar

31. Dete filed (Month, Dey, Year)

MAR 1 6 2000

32. Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMEND#8 PER F.H. G781 3-16-2000 JAB Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 1535 Lincoln George 03 09 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City NIA 5. Social Security Number of Maryland System Medical 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 7/24/30 (Month, Day, Year) 4/30 6. Sex Birthplace (State or Foreign Country) **Funeral** Days 10 M 20 F 216-24-9499 69 Maryland Director **Usual Residence of Decedent** 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits N 1 Yas 2 No Director M.D. notifie B BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b finer must be 4649 ROKEBY ROAD 21229 U.S.A 12. Was Decedent Ever in U,S. Armed Forces? 1 20 Yes 2 10 No If Yes, Give Year or Dates: 1951 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status Black, Whita, etc. 72 hours after 1 □ Never Married 2 N Married h and Mental Hygiene. 7 is marked other than "naturel", or traumatic event, the Medical Exami 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) SOCIAL SECURITY filled within Elementary/Secondary (0-12) College (1-4or 5+) 2 YEARS PHOTOGRAPHER **ADMINISTRATION** Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Pages 1 and 2 should be III ment of Health and Mental H tent: If them 27 is marked oth lury or other traumatic even 88 JOSEPHINE GAINES TEACKLE WALLIS LANSEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) , WIFE ROWENA LANSEY 4649 ROKEBY RD. BALTIMORE, MARYLAND 21229 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARRISON FOREST VET. CEMT. 3/14 OWINGSMILLS, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility NUTTER FUNERAL HOME & INC 2501 GWYNNSFALLS PKWY BALTO, M.D. 21216 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical Anoxic brain injury Examiner Examine Subarachnoid henorrhage Supdural attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Renal failure Records, à 24b. Were autopsy findings available prior to completion of causa of death? Completed 24a. Was an autopsy performed? page 2 1 Yas 2 No of Vital 25. Was casa referred to medical examiner? Medical Certification: To Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 12 npatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) After this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 5 Pending investigation or Attanding To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No 0 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, tarm, street, tactory, office building, etc. (Specify) 4 ☐ Homicide List Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 03/09/00 P14147

Registrar **DHMH 16 Rev 6/95**

State

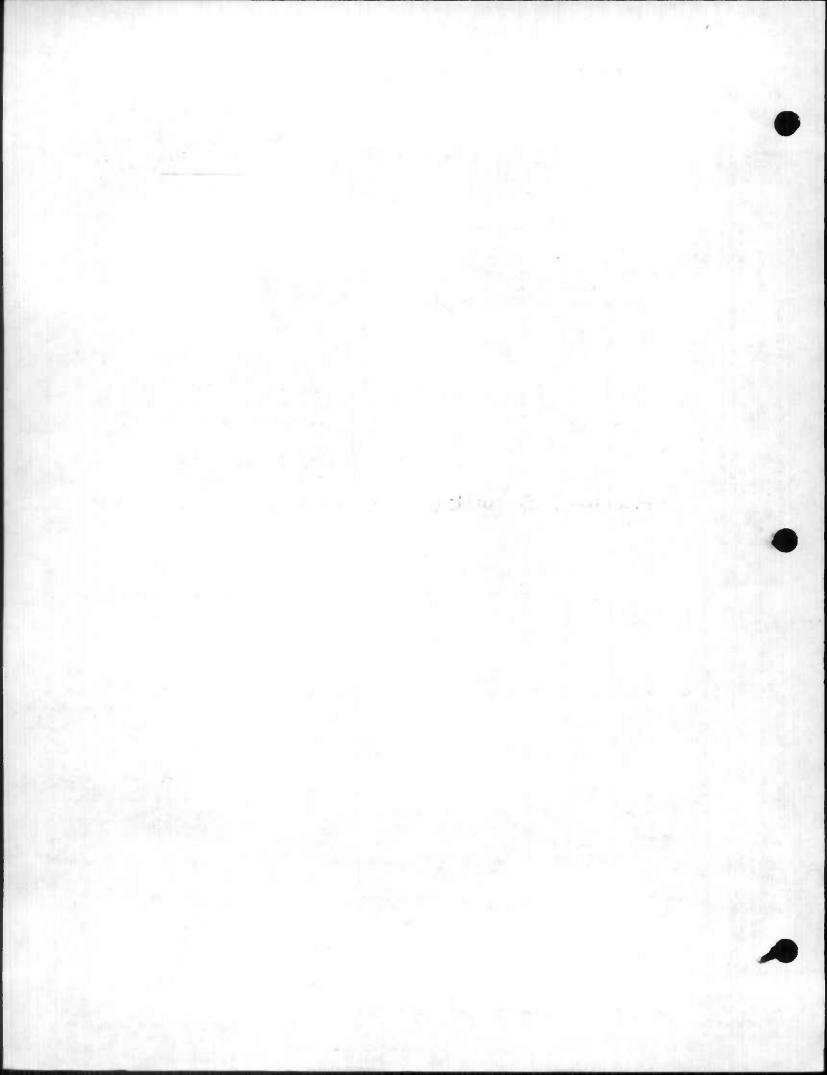
22 South- Greene Street Baltimore City, Maryland

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signature

Cynthia J. Bucci 31. Date filed (Month, Day, Year)

MAR 1 6 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death AMENDED ITEM #12 PER FH G781 3/16/2000 AH 1. Decedent'e Name (First, Middle, Last) 2. Data of Death 3. Time of Deeth Month Year **Physician** 6, 9:45A DOROTHY MUSGROVE March 7.000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Hospital of Sigai If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) **Funeral** Days 1□ M 2Ĭ F Months Yrs. Director 090-14-8318 80 Sept 22, 1919 NY Usual Residence of Decedent 10a State 10b Count 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 11 Yes 2 □ No Director notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? munt be n 1486 Medfield Ave 21211 USA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1942 1 (2) Yes 2010 If Yes, Give Year or Datas: 14. Raca - American Indian, Bleck, White, etc. 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Merried 8 1 ☐ Yes 2 No Specify: white þ 3 ₩idowed 4 Divorced Jorothy Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) plastics line worker unknown Baltimore, Maryland 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be 1 and 2 should be Health and Mental Delia Unger George H. Peters 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) nt of Health a if Item 27 is or other train 1486 Medfield Ave Baltimore, MD Stuart Musgrove/son 20b. Plece of Disposition (Name of cematery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Pages nent of h 1 Burial 2 Cremation 3 Removel from State 4 Donetion 5 ☐ Other (Specify) 21. Signature of Eurieral Service 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Wade, Director Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory arrest, but, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death **Physician** /Medical Immediete Cause (Finel disease or condition resulting in deeth) Exacerbation COPA Examiner Due to (or as e consequence of): Examiner Branchitis Chronic the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Last Due to (or es a consequence of): pue Box 68760, Physician/Medical Due to (or es e consequence of): 8 for use Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yee 2 No 3 Probably 4 Unknown Hypertension, Extensive Engarate smoking history Division of Vital Records, Completed by 24a. Wes an autopsy performed? 24b. Were autopsy lindings aveilable prior to completion of cause of death? this certificate 2 00 No 1 Yes 1 ☐ Yes 2 No Attending Physician: 25. Was case referred to medical axaminer? Be 26. Place of Deeth (Check only one) Hospital: 1 KInpatient 2 □ ER/Outpatient 3 □ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Medical Certification: To 1 Yes 2 XNo uneral 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident after death Director: / 3 ☐ Suicide 6 Could not be determined 28l. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, lerm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours aft Funeral Di letely filled in Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

State Registrar

completely

within 2 To the

29a. Certifier

(Check only one)

29b. Signeture and little of certified

32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sinai

M.O.

Hospital of Depena

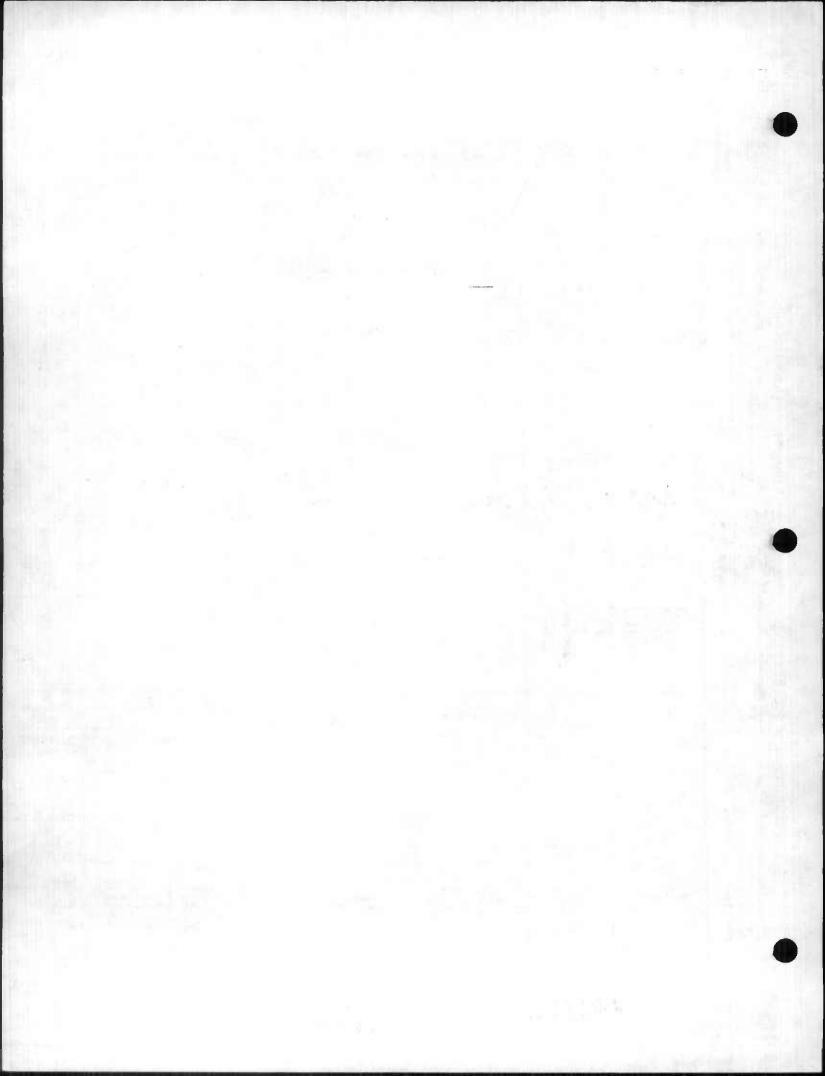
29c. License number

- 13206

29d. Date signed (Month, Dey, Year)

6,2000

March



Certificate of Death

2. Data of Death

Month

3. Time of Death

8:00AM

10d. Inside City Limits 1 Yas 2 No

Approximate Intarval Between Onset and Death

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 30 No

MONTHS

Birthplace (State or Foreign Country)

Germany

14. Race - Amarican Indian, Black White etc.

White

Specify:

2000

Baltimore

1. Decedant's Name (First, Middla, Last)

Physician

State Registrar

DHMH 16 Rev 6/95

TATHEW V.

31. Data filed (Month, Day, Year)

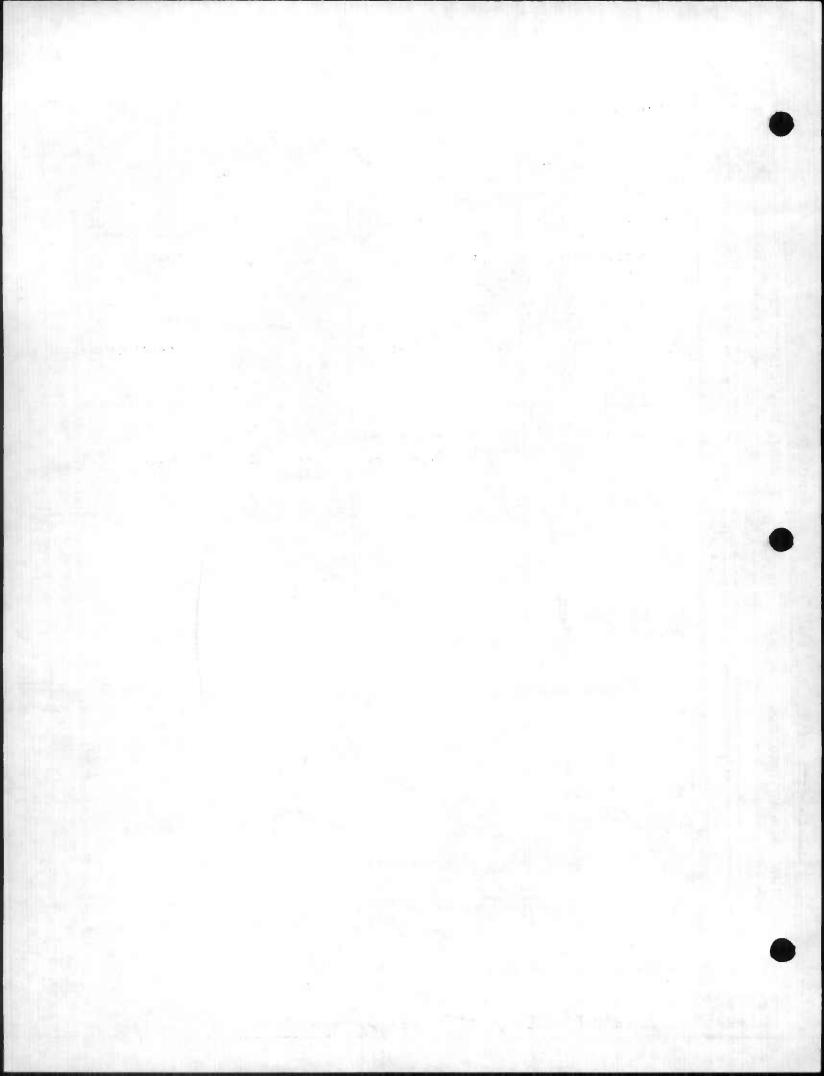
30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

NARRETT

32. Registrar's Signatura

711 MAIDENCHOICE ANE CATIONSVILLE, MO 21228

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1010 Physician Jarch BRICE MORELAND /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b_City, Town, or Location of Death Examiner lary/and Creneral 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 X M 2 □ F Yrs. 216-38-2802 Director Sept 14, 1939 unknown Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be r 601 Wynote Avenue 21218 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No
It Yes, Give
Year or Dates: unknown 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: g 3 ☐ Widowed 4 ☐ Divorced white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) unknown Elementary/Secondary (0-12) 276 unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be should be Montal unknown unknown 19a. Intormant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) ñ mportant: If Item 27 Md General Hospital 827 Linden Ave Baltimore, MD 21201 20b. Place of Disposition (Name of cametery, crematory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition Pages 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8 4 ☐ Donation 5 ☒ Other (Specify) in State 21. Sunuture of Fundal Service Licensen Ronald S. Wade, 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director 2 21201 Baltimore, MD 111. Enter the disease, or compli hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting In death) Examiner Examiner eremia the death certificate be executed physician and the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es a consequence of) Physician/Medicai that initiated events resulting in death) Last Due to (or as a consequence of) 80 USB for ed by the s 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 | Yee 2 | No 3 | Probably 4 | Unknown The law requires that by should b 24b. Were autopsy tindings available prior to completion of cause of deeth? 24e. Was en autopsy performed? Completed 1 Yes 2 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical exeminer? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 1 Impatient 2 ER/Outpatient 3 DOA

certificate hes b lirector, page 2 s

or Attending Physician: this funeral death. oftar deatl 2

P.O. Box 68760, Division of Vital Records, • Funeral Di Hospital Within 2 To the I

> State Registrar

Certification:

27. Manger of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 \ Homicide

(Check only one)

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28t. Location (Street and Number or Rural Route Number, City or Town, State)

5 Pending

Investigation

6 Could not be

eted cause of death (Item 23e) (Type, Print) m. A. 40

28e. Dete of Injury (Month, Dey Year)

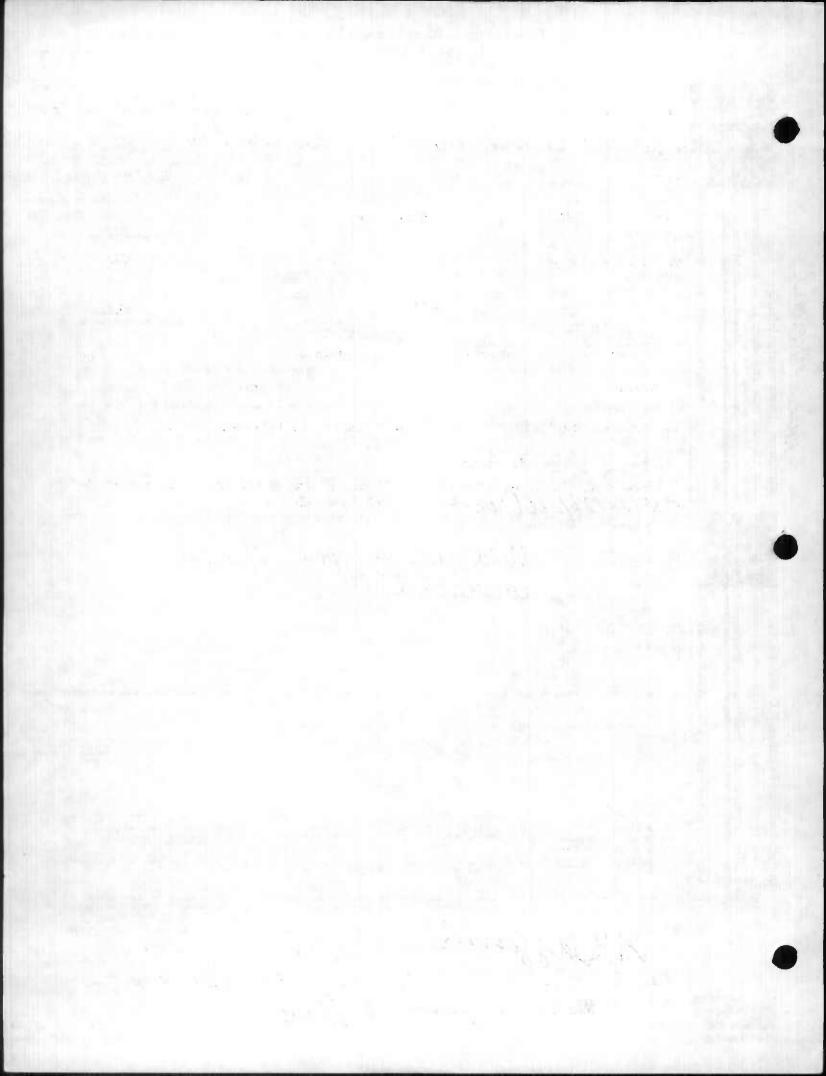
General Hospital

28d. Describe how injury occurred

2000 Registrar's Signature

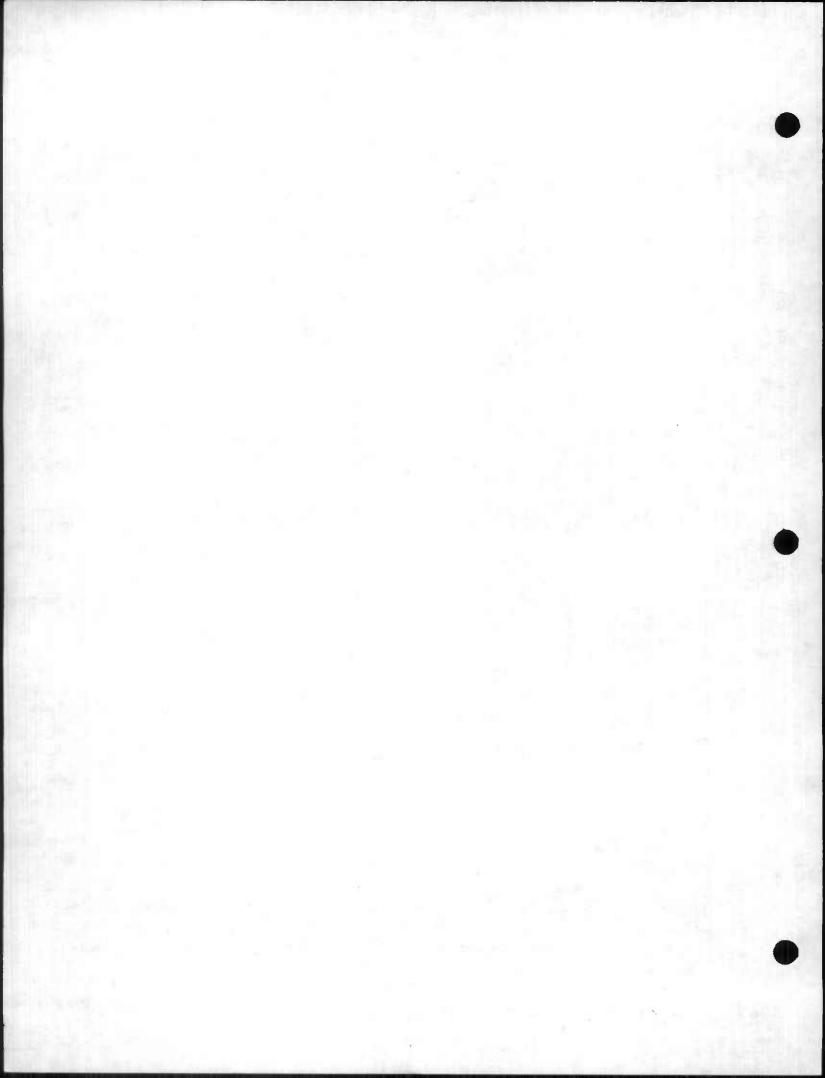
28h Time of

28e. Placa of Injury - At home, tarm, street, factory, office building, etc. (Specify)



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State of Maryland / Department of Health and Mental Hygiene 08850 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 12:58 pm Bertha Elizabeth Moore march 15,2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin square flospital center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 10 M 2 F Days Hours 84 Yrs. Director 219-82-711 July 23, 1915 Maryland Usual Residence of Decede 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. Inside City Limits River 1 Yes 2 No Middle Baltimore Funeral Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21220 , A. River Drive U.S 6820 North 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Bleck, White, etc. 72 hours after 1 Yes 2 No 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: 21215-0020 Specify: White p 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Home Homemaker 6 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) leges 1 and 2 should be fit and of Health and Mentel Hit: If item 27 is marked oth y or other treumatic avem 8 Benjamin 6. Kaa unknows 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Many A. Hart-Bennett-daug 20a Method Disposition 1 Burial 2 Cremetion 3 Removal from State River 6820 North Drive Baltimore, MD 21220 205. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stete March 18 Department 4 □ Donetion 5 □ Other (Specify) 2000 Middle River MD Hill Cemetery 21. Signature of Funerel Service Licenses 22. Name and Address of Facility of memones wans chaper of memo Harford Rd. Baltimore Evans leath 0088 MD21234 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) . Sepsis 20 Days Examiner Due to (or as a consequence of) Examiner The law requires that the death certificets be executed pue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. physicien the burial Completed by Physician/Medical Due to (or as a consequence of): for use signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Renal Failure Multi Infarct Dementia, Hyporten Sion Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Malnutrition, cerebrovascular accident 1 Yes 2 No 1 ☐ Yes 20 No certificate clostridium Difficile colitis or Attanding Physicien: funeral director, 25. Wes case referred to medicat examiner?

1 Yes 28'No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 26a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation 1 Netural 2 Accident s efter death. 1 TYes 2 DNo 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital within 24 hours or To the Funeral I completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifie (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number march 15,2000 Marco Jamere 30. Name and address of person who empleted cause of death (Item 23a) (Type, Print) DR marco AMORA 9000 Franklin Square Drive Baltimore mD ala87 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

Registrar

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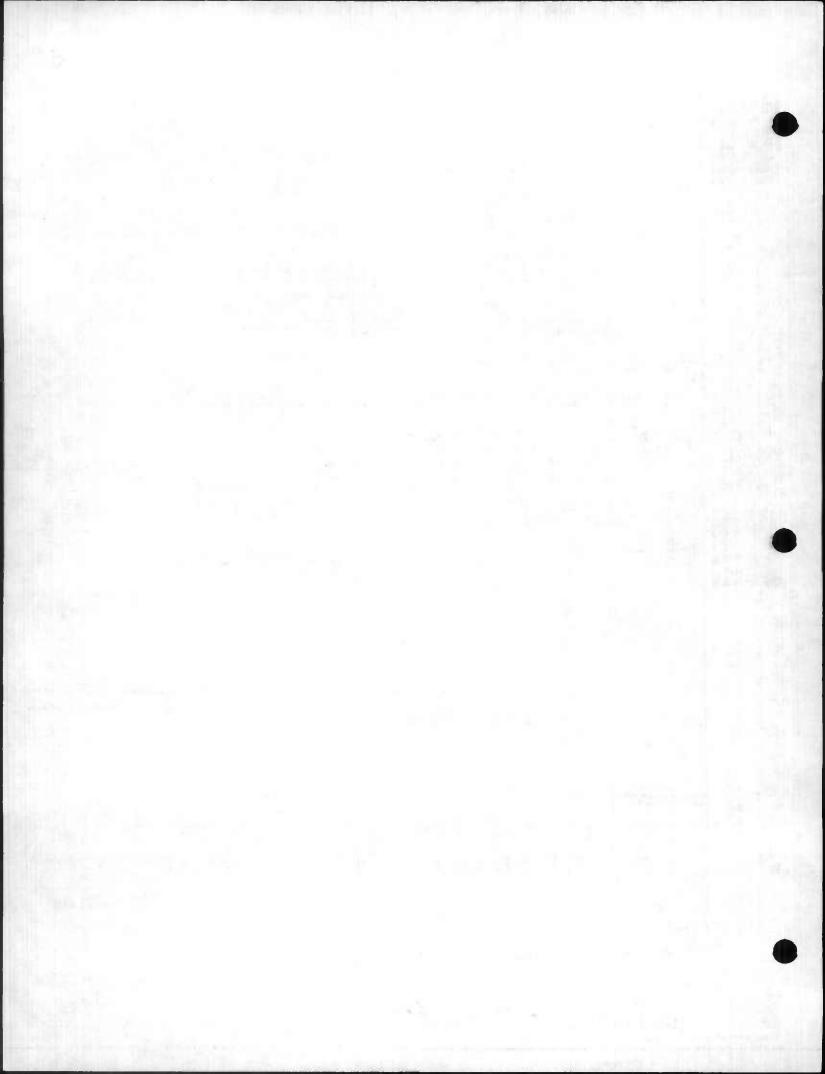
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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08851 Certificate of Death amended Item#10b,c,e,f perFHG781 3/16/2000 EW 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Dete of Death **Physician** 30Am 2000 1 /Medical Fecility Neme (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MILLEY If Under 24 Hrs. DRIVE NO. 7. Age (In yrs. last birthday) If Under Months 9. Birthplace (State or Foreign 8. Date of Birth (Month, Dey, 5. Social Security Number 6. Sex Funeral Deys 1 M 2 PF Hours 239-42-6772 Usuet Residence of Decedent Director the Meryland 10a. Stete 10b. County 10c. City, Town or Location x 28a-f show 10d. Inside City Limits Anne Arundel Millersville 1 Yes 2 No Director MARY 10e. Street and Number 8227 Bernard Drive North 10f. Zip Code 10g. Citizen of What Country? 21108 ms 23a or by Funeral 12. Wes Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: 14. Rece - American Indien. 11. Meritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or Itan Bleck, White, etc. filed within 72 hours effer 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Ack Specify. 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Cotlege (1-4or 5+) Elementery/Secondary (0-12) Hygiene. 5 E WITE 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Peges 1 and 2 should be in nent of Heelth and Mentel I -CE UNSTUS WiggIN. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) > 10 nt of Heelth a If item 27 is or other tra ERSV 20b. Pleca of Disposition (Ne Method of Disposition

Buriel 2 Cremetion 3 Removet from Town, State Dete 20c. Location -Department of Important: If any injury or 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licenses MARS 2/220 LI 23a. Pert1. Enter the disease, or complications that can led the deeth. Do not enter the mode of dying, such as cardiac or responds, or heart failure. List only one ceuse on each line. Approximate Intervel Between Onset and Death Physician /Medical tmmediete Cause (Final diseese or condition resulting in deeth) Examiner Physician/Medical Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of) The law requires that the death certificate be axe Due to (or as e consequence of): for use P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 down Division of Vital Records, Be Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 2D No After this certificate 1 Yes 2 1 No 1 Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Dete of tnjury (Month, Dey Year) 27. Menney of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 TYes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide Location (Street end Number or Rurel Route Number, City or Town, State) Pteca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide Hospital 29e. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the ceuse(s) end manner as stated. completely 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner steted. (Check only one) the 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) CATTIN 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08852. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Michael 17:20 Melnick March 14, 2000 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death N/A Johns Hopkins Hospital Baltimore City If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 220-76-7660 40 MD Usual Residence of Decedant 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No MD Howard Ellicott City 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8815 Manahan Drive 21043 United States 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bieck, White, etc. 1 Yes 2X No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2€ No Specify: Specify 3 Widowed 4 Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Accountant Defense 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) James E. Melnick Carolyn J. Ziolkowski 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Marian P. Melnick/Wife 8815 Manahan Drive Ellicott City, MD 21043 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) St. John's Cemetery 3-20-2000 Ellicott City, MD 21. Signeture of Funerel Service Licenses 22. Name end Address of Fecility Harry H. Witzke's Family Funeral Home, Inc. mo1044 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. 4112 Old Columbia Pike Ellicott City, MD 21043 Immediate Cause (Final Cardiac Tamponade 20minuets disease or condition resulting in deeth) Due to (or es e consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Myocarditis 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy 1 Yes 2 No 1 X Yes 2 □ No 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how Injury occurred 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work?

Examiner Box 68760, Physician/Medicai the P.O. Records. Sign Dec Completed Division of Vital Be edicai Certification: To

Physician

/Medical

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Director

Funeral

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Itsme 23a or

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Pages 1 and 2 should be nent of Health and Mental

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Department of Heath a Important: If Item 27 Is any injury or other tra

Physician /Medical

Examiner

altimore, Maryland 21215-0020

Hospital or Attending Physician: After s after death. filled in by To the Hospital of within 24 hours a To the Funeral D completely filled

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25. Was case referred to medical examiner? 1 Yes 2 XNo 27. Menner of Deeth 5 Pending investigetion 1 Naturel
2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred et the time, dete and place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of sertifier nas RES-000

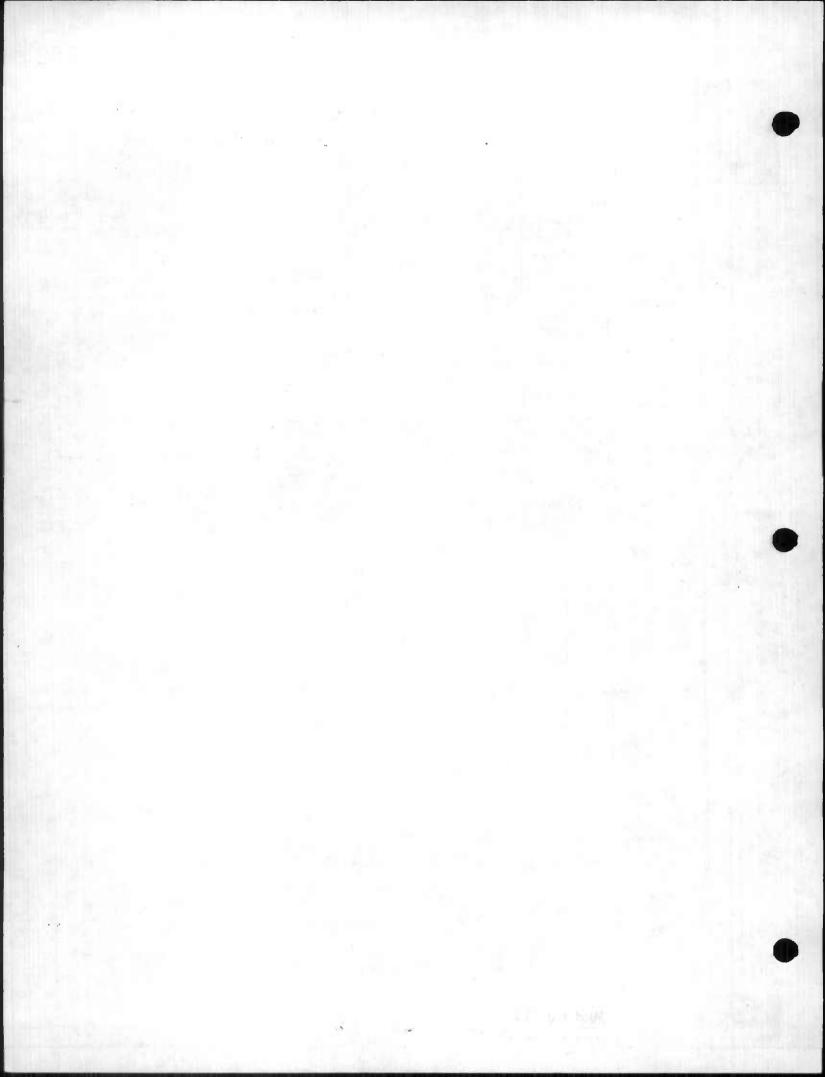
30. Name end address of person who compléted cause of deeth (Item 23a) (Type, Print)

Johns Hopkins Hospital 600 N wolfe Street Baltimore, MD 21287 Rozen

March 14, 2000

State Registrar 31. Dete filed (Month, Dey, Year) MAR 16 2000

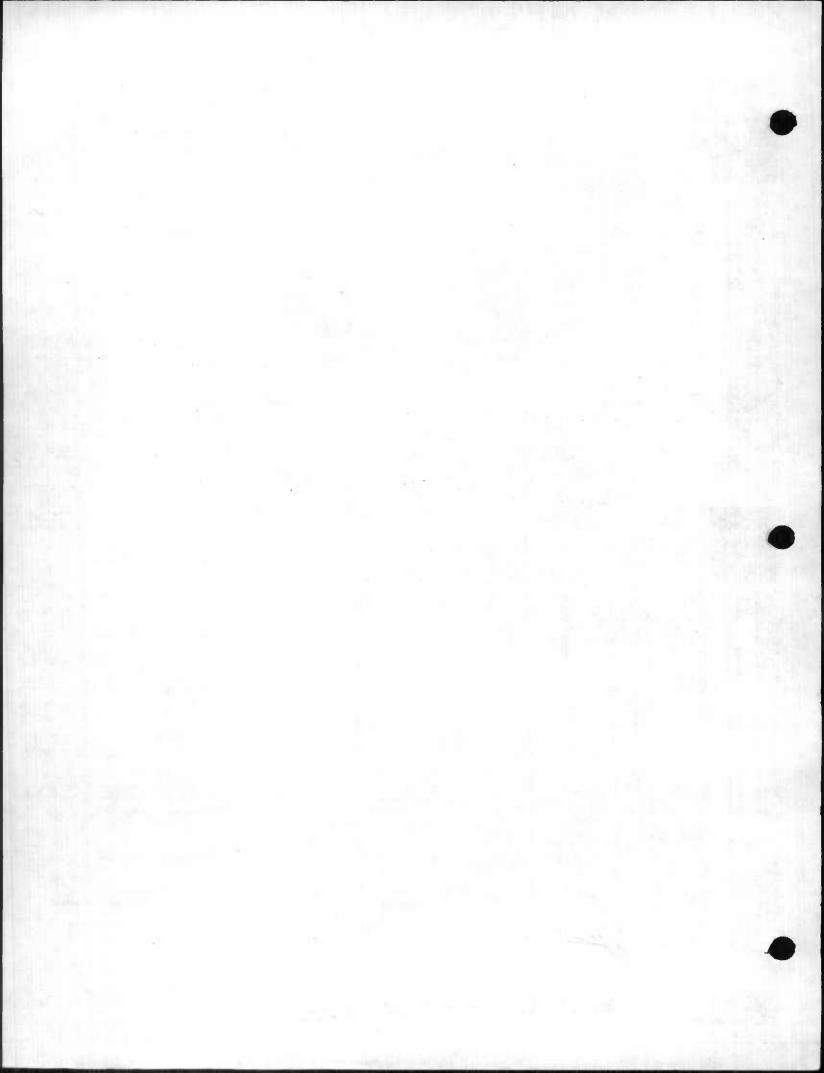
32. Registrest Signeture



State of Maryland / Department of Health and Mental Hygiene () () () () () () () () ()

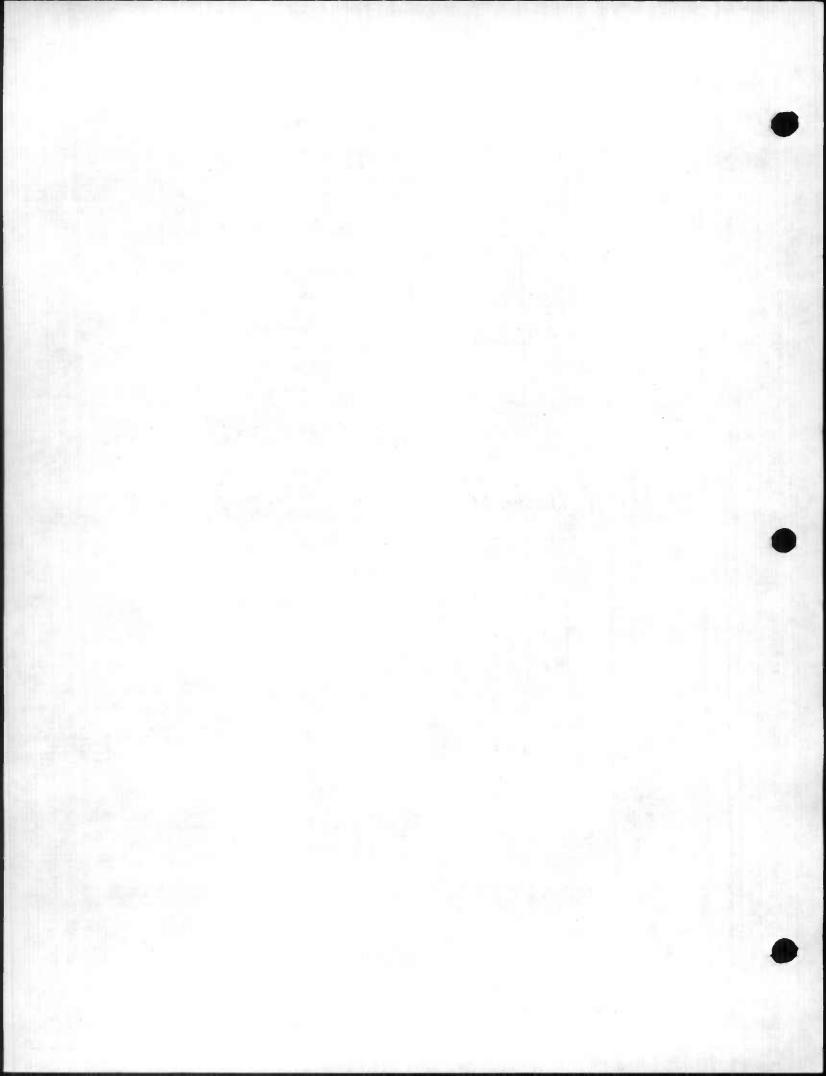
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eath and Mental Hygiene n 27 is marked other than "natural", or itsms 23e or 28e-f show nor traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	10b. County Maryland Baltin 10c. Street and Number 626 Braeside Road 11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E (Specify only highest gr. Elementery/Secondery (0-12) 17. Fathar's Nama (First, Middla, Last ISACC P.Calvert 19a. Informant's Name/Relationship (12. Was Decedent E Armed Forces? 1	Balt Ever in U.S.	13. Wes I II Yes	Dr. Zip Code 21229 Decedent of H s, specify Cub		Specify Yas or No	USA	1 ☐ Yes 2 P No	
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n 27 is marked off ner traumatic even To Be	Isacc P.Calvert 19a. Informant's Name/Relationship (John J. McKechnic			Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)			rking	16b. Kind of Busi	ness/Industry	
n 27 is	John J. McKechnie			Nurse	=	18. Mother's Na Edna Ca		Maiden Sumame)	
1 2	Maria Adams and Adams and Maria							er, City or Town, S esda, MD		
ury or	20a. Method of Disposition 1 ☐ Buriel 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		cemete		n (Name of ny or other pla Cemet		Date 3/16/00		ity or Town, State e, Maryland	
tuodui 2	21. Signature of Funeral Service Lice	Weller	CFS	Davi 5311	me and Addre Ld J. V Edmor	veber Fur ndson Ave	neral Hor enue Balt	mes, P.A. Limore, M	aryland 21229	
sician	23a. Part1. Entar the disease, or com shock, or heart failure. List only				mode of dyi	ng, such es cardia	c or respiretory a	rrest,	Approximete Intervel Between Onset and Death	
miner	Immediate Causa (Finel disease or condition resulting in death) Septic Shock Due to (or as a consequence of): Metastatic Breast Cancer								24 hours	
Examiner Examiner	Sequentially list conditions,				10 yrs.					
Aedical	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Due to (or as a	consequence	e of):					
d for use	Part II Other elgoificent conditions	ontributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use or						tobacco use cont	contribute to the cause of death?	
by Physician/	an ii. Other significant conditions of	nitibuting to death but not resulting in the underlying cause given in Part I.						1 □ Yes 2 □ No 3 □ Probably 4 ☑ Unki		
2 should pieted		3,43					24a. Wes	ta. Wes an autopsy performed? 24b. Were autopsy available prior completion of death?		
Com							10	Yes 2 No	1 Yes 2 No	
To B	25. Was case referred to medicat examiner? 1 Yes \$ No	Hospital:	-28		LI DON	her: 4 Nursing I	1	dence 8 Other		
Te Lo	1 Natural 5 Pending 2 Accident Investigatio 3 Suicide 6 Could not b	(Month, Day Year) Injury Work? I □ Yes 2 □ No						28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number)		
	4 Homicide determined	28e. Place of Injurbuilding, etc.				me date and oler-	City or To	wn, State)		
pletely fill edical		niner: On the basis of a	examination er							
S S S S S S S S S S S S S S S S S S S	29b. Signature and blery confine				29c. Licens D5238			29d. Dete signed March 13	(Month, Day, Year)	
State 3	a w	completed cause of de	ath (Item 23a)	(Type, Print)						

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State of Maryland / Department of Health and Mental Hygiene 00 08854

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Discontinues.	1. Decedant's Name (First, Middla, Li	ast)						2. Date of Deal Month	th Day	Year	3. Time of Death
Physician /Medical	Edna L. Melton							March	13, 200		8:00 pm
Examiner	4a Facility Nama (If not institution, gi	4	b. City, Tow		cation of Death						
Examine.	Manor Care Tows		Tov		В	altin	ore				
Funeral	5. Social Security Number 6.	Sex 7.7	Aga (In yrs. last birth		r 1 Year	If Under 2	4 Hrs.	8. Dala of Birth			lace (Stata or Foraign
Director	213 16 6517	1□M 2⊠F	87 Yr	s. Months	Days	Hours	Min.	8. Dala of Birth (Month, Day) NOV . 12,	1912	Coun	ryland
	Usual Rasidence of Decedent										
8 =	10a. Stata 10b. County		10c. City, Town	or Location						1	0d. Inside City Limits
to to	Maryland Baltim	ore	Esse	3X							1 ☐ Yas 2QNo
or 28a-fa	10e. Street and Number 10f. Zip C				Code			1	Og. Citizen of \	What Coun	try?
D 20	1000 Franklin Ave. "Apt 708"					1			US		
al; or items 23a or 28e-f show Examiner must be notified at by Funeral Director	11. Marital Status	12. Was Deceder					in? (Sno	cify Yes or No-		e - Amaric	an Indian
La Par	1 Never Married 2 Married	Armed Forces	37	If Yas, spe	cify Cuba	n, Mexican,	Puerto F	Rican, atc.)		k, White,	
by B	3 ☑ Widowed 4 ☐ Divorced	If Yas, Giva Year or Dates		1 🗆 Yas	2 🔀 No	Specify:			Specify	. Whi	.te
thyjene. thy than 'natural', or heme 23e or 28e-f ahow and, the Nexteel Emminer must be northed at	15. Decedant's E			ecedent's Usu	al Occupi	ation			16b. Kind of B	usinace/Inc	luctor
e e	(Specify only highast gr	ade completed)	()	Give kind of wo	ork dona d	during most	of workin	9	TOO. KING OF D	usit lassi irre	iostry
ygiene. Nor than "naturn It, Tre Process Completed	Elementary/Secondary (0-12)	Collega (1-4o		chine						oring	
E S	17. Fathar's Nama (First, Middla, Las.	e)				18 Mother	's Nama	(First, Middle, I	Maiden Suman	20)	
Ties of the state	John M. Gray	,								,	
th and Mental Hygiene. 7 is marked other than traumatic avent, the M	19a. Informant's Name/Ralationship	(T D-1-1)	401.0	a-101 A-3-3	. (0)			Kenney		Ote to The	0-4-1
h an T la r	Lloyd Farrow Sr.			3				Routa Number			
= 01 -		(121010)	20b. Place of D	00 Fran		Ave.	Apt		Balto.,		
0 = 5	20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 €	Removal from Stat	cematary,	crematory or	othar plac				20c. Location -		
Department Important: II any Injury o once.	4 Donation 5 Other (Special	ify)	Lake Vi	.ew Mem	. Par	rk 3/	16/2	2000	Sykesvi	lle,	Md.
Departmen important: any injury once.	21. Signature of Funeral Service Lice	nsee 0	0	22. Nama a	nd Addras	s of Facility	none	al Home	D 3		
Par	I John W 4	war barrer	Do	1407	Old	Faste	ern A	Avenue I	P.A. Essex.	Md. 2	1221
	23a. Part. Enter the disease, or con	nplications that caus	ed the death. Do no								Approximata
nysician	sfig6k, or heart failure. List only		Onset ar		Intarval Between Onset and Death						
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ist-transit Examiner		b								<u> </u>	
al-tra	Sequentially list conditions, if any, laading to immadiate causa. Entar Undartying Cause (Disease or injury C.										
Sicial Puri	Cause (Disease or injury that initiated events	c	B 11. (1								
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to to						Id tobacco use contribute to the cause of death					
ed by the detached	Part II. Other significant conditions	contributing to death	but not resulting in t	ha undarlying	causa give	en in Part I.			Δ.		
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be det										0.45 W/	an autonou lindina
P 79								24a. Was a perform		ava	ara autopsy lindings milable prior to mpletion of cause
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has been s ge 2 should mpleted								1 🗆 Yı	as 2 No		Yas 2□ No
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certificate has been s lirector, page 2 should o Be Completed	25. Was casa rafarred to medical axeminar? 1 □ Yas 2⊠ No	Hospital: 1 □ Inpa	tient 2 ER/Outp	atient 3□ D	OA Oth	ar		(Check only or	na)	10	
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24 hours after death. Funeral Director: After this certificate has the fine funeral director, page 2 sitely filled in by the funeral director, page 2 siteal Certification: To Be Completing	axaminar? 1 Yas 2 No 27. Mannar of Death 1 Natural 5 Panding invastigation 2 Accidant 3 Suicide 6 Could not be detarmined. 29a. Certifiar (Check only 2 Medical Examond) 29b. Signatura and old of counting.	28a. Data of In (Month, L) 28a. Placa of I building, i	ury 28b. Times Injury - At homa, larmatic. (Specify) t of my knowledga, coff axamination and/stated.	na of Inny M M In, street, lactor M M M M M M M M M M M M M M M M M M M	28c. Injun Word 1 0 y, office at tha tim i, in my op	er: 4 Nur y at c? Yas 2 Nur Yas 2 Nur na, data and pinion, daatt	sing Hon 2 to 2	(Check only or na 5 Raside 8d. Describe his City or Town and dua to that and at the time, d	ence 8 Othow injury occur tireet and Numb n, Stata) ause(s) and ma ata and place,	1 [sar (Specification of the state of the s	I Routa Number, ated. tha cause(s)
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician 1 7:00am MARCH 3 2000 MARY ALICE MCDONALD-JOHNSON /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 704 LENNOX ST BALTIMORE If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 250 F Yrs Director 59 04-05-40 243-60-8644 ROCKHILL, SC Usual Residence of Deceden 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 'natural', or hams 23s or 28s-f show MD N Yas 2 No N/A Director BALTIMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 704 LENNOX STREET Funeral 21217 U . S . A .

14. Raca - American Indian,
Black, White, etc. 12. Was Decedent Ever in U,S.
Armed Forcas?
1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, atc.) 1 Never Married 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify. BLACK Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within Hygiene. Elementary/Secondary (0-12) Collega (1-4or 5+) CAREPROVIDER 12 SELF EMPLOYED permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy, important if them 27 is marked other any injury or other them. 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Maiden Surnama) Be GEORGE KING ISABELLE HEMPHILL 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MR. OSCAR JOHNSON, HUSBAND 704 LENNOX STREET, BALTO. MD 21217 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place 1 D Burial 2 □ Cramation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ure of Fundral S 21. Signat 22. Name and Address of Facility HOWELL FUNERAL HOME 4600 LTBERTY HGHTS AVE, BALTO. It enter the mode of dying, such as cardiac or respiratory errest, MD 21207 ns thet caused the death. Do not enter the mode of dying, such as cardiage on each line. Approximete Interval Between Onset and Death 23a, Part E . Enter the disease, or co k, or heart fallure. List on **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-tran Due to (or as a consequence of): certificate be execu Box 68760. Physician/Medical eu Due to (or as a consequence of): for use as The law requires that the death P.O. 1 signed by the s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? t ☐ Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy peen 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director. 25. Was case referred to medical 8 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 27. Mennar of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending deeth. s after dee. 1 ☐ Yes 2 ☐ No 2 Accident investigetion 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI completely filled in 16 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year)

State Registrar

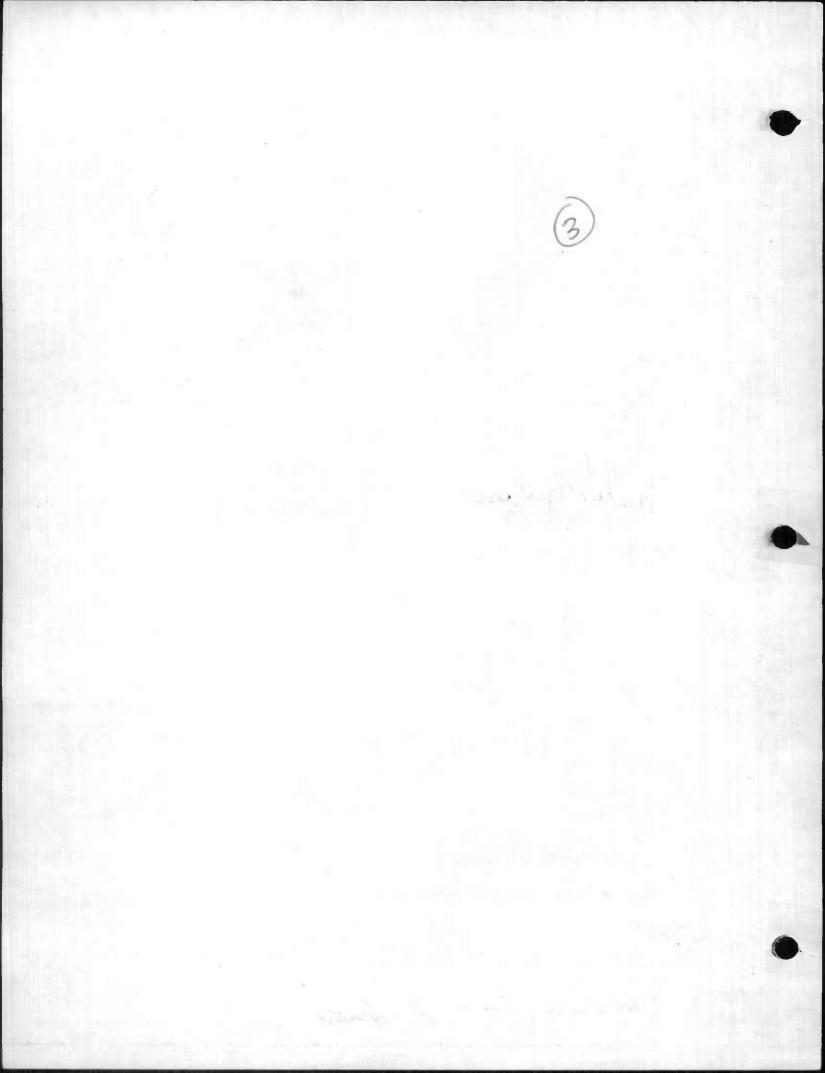
DHMH 16 Rev 6/95

S. GREENS

ALTIMORE, MD

of person who completed cause of daath (Item 23a) (Type, Print)

/ 32 Registrar's Signature



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 IAN 4a. Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death

Physician /Medicai Examiner

Funeral Director

with the Maryland Pegas 1 and 2 should be filed within 72 hours after death with the Marylar nent of Health and Manthel Hygiene. Intent of Health and Manthel Hygiene. Intil I flema 27 is marked other than "naturel; or flema 23a or 28a-1 show lint: If flema 27 is marked other than "naturel; or other traumatic event, in a feet fram new manther project and any or other traumatic event, in a feet frame new manther traumatic event ev

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

permit. Pegas 1 and 2 s Depertment of Health ar important: If Item 27 Is any Injury or other trau

To the Hospital or Attending Physiolen: The law requires that the death certificate be associated within 24 hours after death.

To the Funeral Director: After this cartificate has been signed by the attending physician and the 98 950 igned by the atter be detached for page 2 director, funeral completely filled in by the

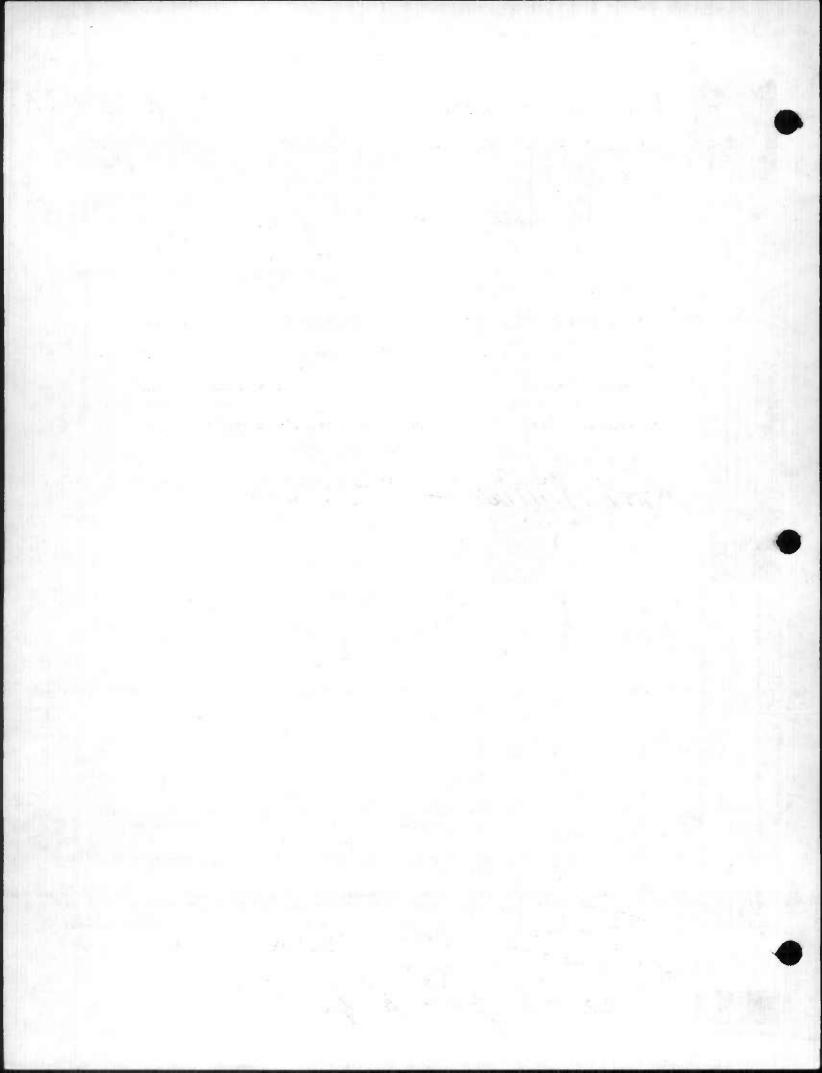
Box 68760.

Division of Vital Records, P.O.

GENESIS ELDERÇARE MULTI MEDICAL Towson Baltimore 6. Sex 1 ☐ M 2 ☒ F If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days Hours 72 Yrs. 212-24-9209 Aug 1, 1927 MD Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ALTIMORE 1 ☐ Yes 2√ No Director Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7700 York Road 21204 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Orlgin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: white by 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) unknown salesperson housewares 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leon Diehl Schoppert Ethel Ruth McMullen 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 21093 Timonium, MD David Nicoll/spouse 35 Oakway Road 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility State Anatomy Board Director 655 W. Baltimore Street 21201 Baltimore, MD ter the disease or complications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate interval Between Onset and Death immediate Cause (Final disease or condition resulting in death) Minutes Physician/Medical Examiner Vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? Stroke, Dementia, 1 ☐ Yee 2 ☐ No 3€ Probably 4 Unknown Atrial Fibrilation Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28c. injury at Work? 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Stated (s) and manner as stated. (Check only one) xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29b. Signature and this of o 29c. License number 29d. Date signed (Month, Day, Year) Hending 811 FICI 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ChWARTZ MelRose 115 M.D

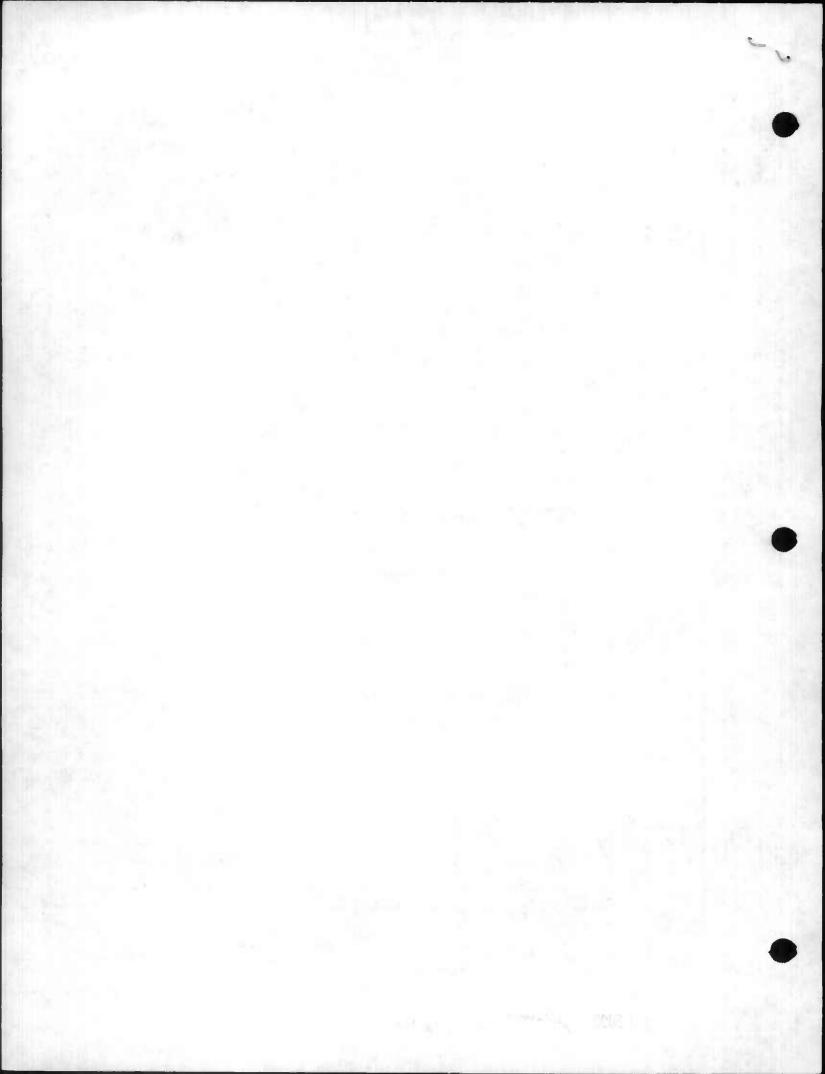
32. Registrar's Signeture

State Registrar



State of Maryland / Department of Health and Mental Hygiene 00 08857

						Certifica	te of	Death	Re	g. No.		00007
			1. Decedent's Name (First, Middle, La	st)					2. Dete of Deetl Month	Dey	Year	3. Time of Death
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	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birt	hday) If Und Months	er 1 Year Deys		8. Dete of Birth (Month, Day,	Year)	9. Birthpl Coun	lace (State or Foreign
н	Director		155 09 4934	IM 20F	8	Yrs.	00,0	1100	FEB.25	1932		RIA
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	Pr de	Funeral	11. Manitel Stetus	12. Wes Decedent E Armed Forces?		If Yes, sp	ecify Cub	Hispanic Origin? (S pan, Mexicen, Puert	o Ricen, etc.)		k, White,	
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8	n 72 hours natural',	8	15. Decedent's E	Yeer or Dates:		Decedent's Us	uel Occui	pation		16b. Kind of Bu	siness/Inc	flustry
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À	Physician /Medical		Immediate Cause (Finel	ME	SOT	HF.I	10	MA-	LUN	G	i i	9 MONTHS
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	death ce e ettendir ed for use	Sicie	Part II. Other significant conditions of	contributing to death but	t not resulting In	the underlying	ceuse gi	iven in Pert i.	23b. Did to	bacco use cor	tribute to	the cause of death?
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0	ith. Afte	i i	1 Netural 5 Pending 2 Accident invastigation	(Month, Day	Y 08/)	njury M		Yes 2 No				
Division	Atter dea bctor	fice	3 ☐ Suicide 6 ☐ Could not b	Zoe. Plece of injul	ry - At homa, fa	rm, straet, fecto	ory, office)	28f. Location (St City or Town		er or Rure	I Route Number,
	afte afte	Certification:	4 Homicide	building, efc.	. (Spacity)				City of Yow	i, Stata)		
	hours hours mera y fille	la:	29e. Cartifier 1 Certifying Ph	nysician: To the best of	my knowledga	, deeth occurre	d et the t	ima, date and place	, and dua to the co	ouse(s) and ma	nnar es s	tated.
	n 24 n Fu	edical	(Check only 2 Medical Exar	miner: On the basis of a and menner atet	examinetion and ed.	d/or invastigation	on, in my	opinion, deeth occu	rred et tha tima, d	ata and place, a	and dua to) the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	X	29b. Signature end title of certifier	00	00	2	9c. Licen	se number	2	9d. Dete signe	d (Month,	Day, Year)
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	10		30. Name and eddress of person who	completed cause of de	eth (Item 23a)	Type, Print)				14 10 000 1	2/4	
			DR MADHUE	LAUDHR	9 000	O FRA	UKT.	in So	UARS D	RIVS 1	Kors	OPS CAPO
	∜ Sta	ite	31. Date filed (Month, Day, Year)	32. Registrei	r's Signature			- A				
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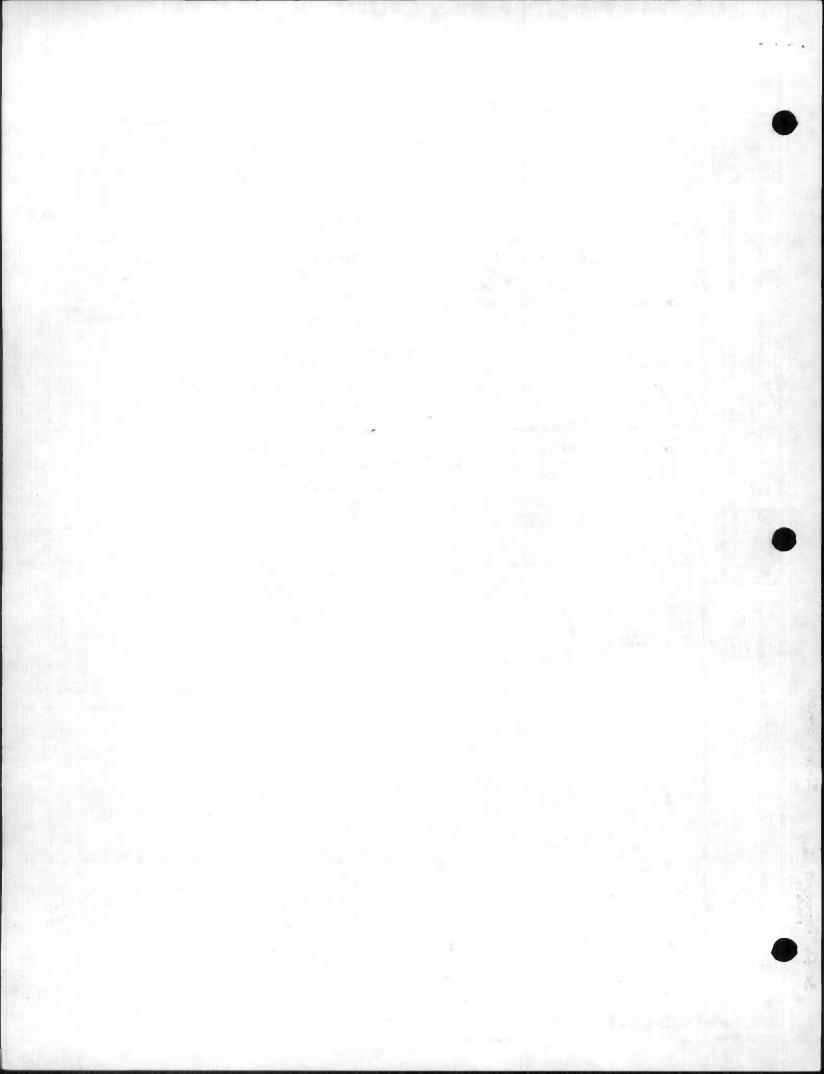


State of Maryland / Department of Health and Mental Hygiene

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	Certificate of Death	Reg. N	lo.	00000
	Decedent's Neme (First, Middle, Last)	2. Dete of Death		3. Time of Death
Physician	GUY EMMETT PUGH	Month E	Day Year	HAM
/Medical	4s Facility Name (If not institution, give street and number) 4b. City, Town, or Lo		Ic. County of Death	1 1-(-) [
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	HARFORD 1 ZMORIAL HOSPITAL HAVRE de		HARFOR	
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birth	place (State or Foreign
or 🗀	212 16 0311	OCT 17.19	ON NORT	HLARDLINE
	Usual Residence of Decedent			
	10a. State 10b. County 10c. City, Town or Location		1	10d. Inside City Limits
to	MARYLAND HARFORD FOREST HILL			1 ☐ Yas 2 💢 No
Directo	10e. Street and Number 10f. Zip Code	10a (Citizen of What Cour	ntry?
Ö	A	109.	3 0 0	
Funeral	2403 BAILEY KOAD 21050		D.S.A.	
	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
	1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No Specify:		Specify: 1 31	
2	3 Widowed 4 □ Divorced Year or Dates:		Specify: W.	377
6	15. Decedent's Education 16a. Decedent's Usual Occupation	16b.	Kind of Business/In	dustry
2	(Specify only highest grade completed) (Give kind of work done during most of work life. DO NOT use retired)	ing		
E	Elementary/Secondary (0-12) College (1-4or 5+)	6.	Tooms	
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Be Completed		t inst, militale, malot	Sumame)	
2	AMBROSE PUGH LORD	N. A. K	3400	
	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Run	al Route Number, City	or Town, State, Zip	(Code) 21050
	PATRICIA RESUSS 2403 BAILEY ROAD	FORST H	11 Mas	Man
	20a. Method of Disposition 20b. Place of Disposition (Name of	Date 20c.	Location - City or To	own State
	12 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)	PARCH 0	- O	own, oraco
		3,2000 132	LHIR ()	ARYLAND
	21. Signature of Euneral Solvice Courses 22. Name and Address of Fecility EVANT FUNCAL CHA	Q 200 10	OPA.	
		WET-12TT-1		31050
	JAEWPORT ORIYE	- FORIST	H.M. 1 JUL	11 2001 11 00
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart feilure. List only one cause on each line.	or respiratory errest.		Approximate Interval Between
	X			Onset and Death
	Immediate Cause (Fine) disease or condition			
	resulting in death)		1	
9	Due to (or as a consequence of):	. 1	1~	
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THE THE	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.			
edical Examiner	that initiated events			
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Cla	Dod II Ohbo also Manager and I	1		
Physician	Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. Did tobacc	o use contribute to	o the cause of death?
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8		24a. Was an eul		ere autopsy findings ailable prior to
Completed		performed?	CO	empletion of cause death?
E			1	Oeatn?
3		1 🗆 Yes	2 No 1	Yes 2 No
Be (25. Was case referred to medical 26. Place of Death	h (Check only one)		
0	examiner? Hospital:) Other:	me 5 Residence	6 DOther (Speci	6/1
⊢	Companient 20 EN Outpatient 30 DON 40 Not still not stil	28d. Describe how in		7/
5	Natural 5 Pending (Month, Day Year) Injury Work?	IOW III		
Certification:	2 Accident investigation M 1 Yes 2 No			
É	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281. Location (Street City or Town, Sta	and Number or Run	al Route Number,
	A Comming and Copposity	, or . own, ore		
9	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the cause	(s) end menner as a	itated
edicai	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurr	ed at the time, date e	nd plece, and due to	o the cause(s)
Med	GO TO THE PLAN CONTROL	1		D V :
=	29b. Signature and title of certifier 29c. License number	7 29d. C	Date signed (Month,	Uay, Year)
	10066		911/01)
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		a de	
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	Jel Mil 067 Keuplulous X.	Davre	00 9118	ce mo
tate	31. Date filed (Mpnth, Dlay, Year) 32. Registrar's Signature			7/10/
trar	MAD 1 6 2000 Beneral D. South			- la

3/11/00 04:00



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08859 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2000 Year **Physician** March 8:00 AM Poe Esther Wisner /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Manor Care Ruxton If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months 1□M 2ØF 220-07-0905 79 Yrs Director 02/04/1921 MD. Usual Residence of Decedent with the Meryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-1 show the Medical Exercises must be notified at 1 ☐ Yas 2 ☒ No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7001 North Chartes St. 21204 USA Funeral deeth Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effect. Department of Health and Mentel Hyglene. Important if New 27 is marked other than "natural". or was injury or other traumado event. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) å Carrie Blanche Kelbauch Charles Wisner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Colony Circle Bedford, MA. 01730 Theodore E. Poe, Jr. (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Steta 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 3/17/2000 4 Donation 5 Other (Specify) Dulaney Valley Mem. Grdns. Timonium, MD. an auture of Funeral Service Licensed PARIS C. Carroll 22. Nama and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 23a. Part I finer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examine erelowo The lew requires that the death certificate be executed physicien end the burief-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as e consequence of) Box 68760. Physician/Medical that initiated events resulting in death) Last Due to (or as a consequence of): signed by the e P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown (1tion Records, à 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 100 1 Yes 2 106 1 TYas 2 No After this certificate funeral director, peg Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No edical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of After or Attending 1 Nettural 5 Pending investigation Injury s efter deeth, f Director: Aft d in by the fun 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours eff To the Funerel DI completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed [Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

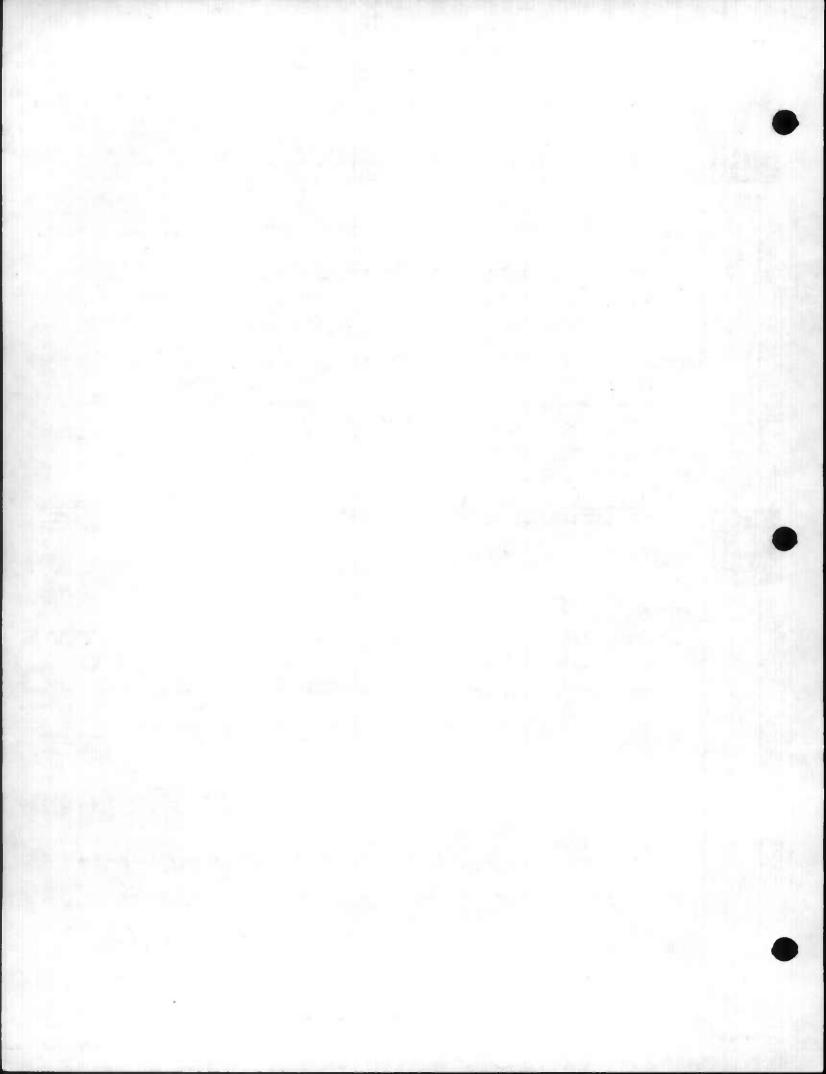
DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signeture

Benevis



To the I within 2

State Registrar

DHMH 16 Rev 6/95

Stephen S.
31. Dete filed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Itemy 23a) (Type, Print)

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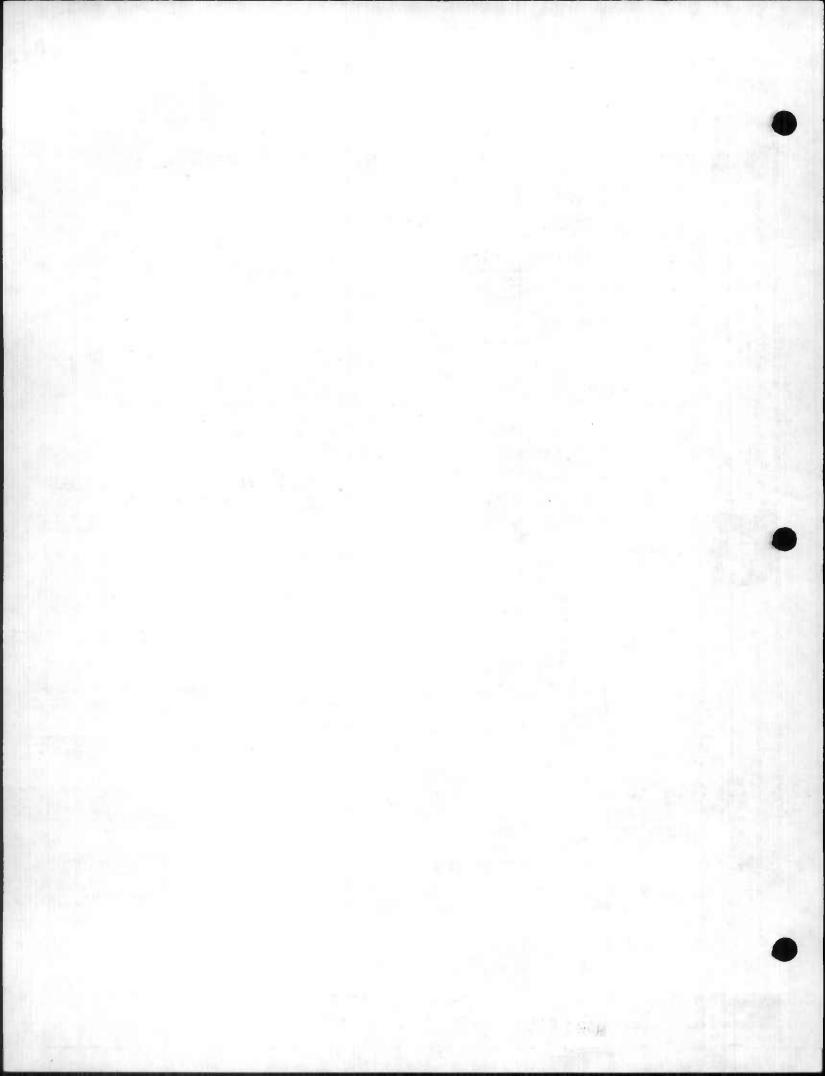
32. Registrar's Signeture

111 Penn Street, Baltimore, Maryland 21201 south

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MARCH 15, 2000

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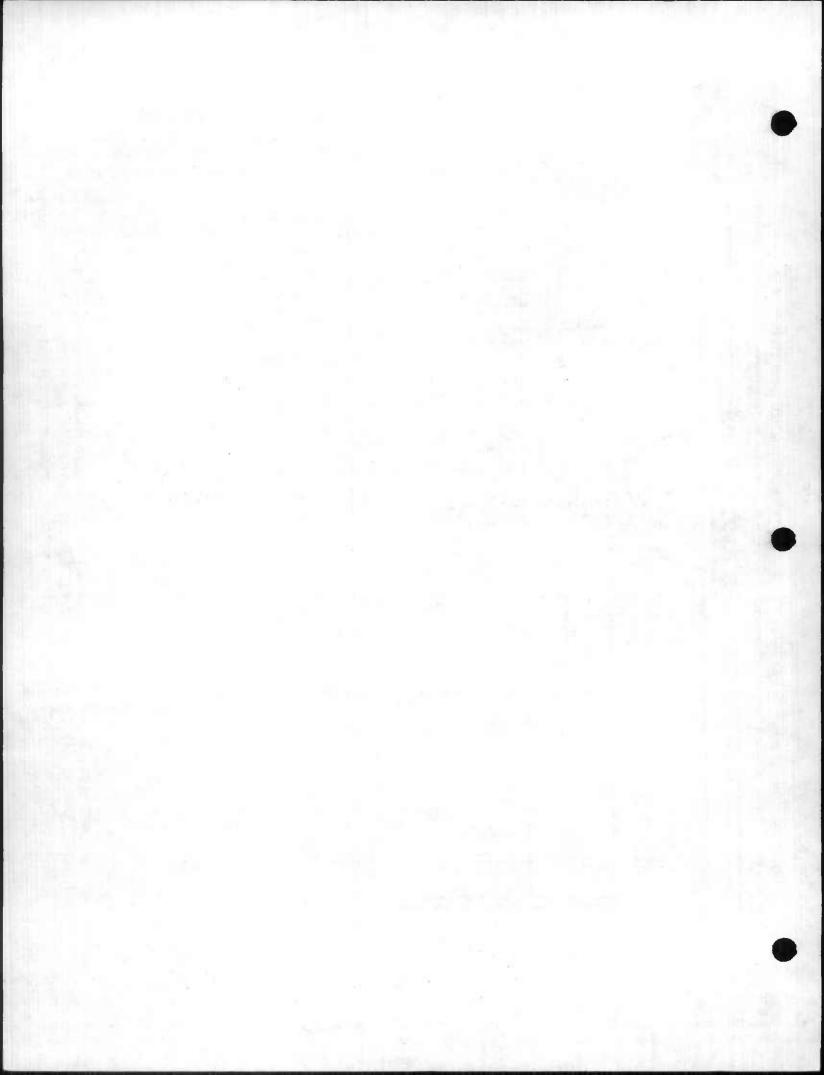


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended Item#8 perFHG781 3/22/2000 EW 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Month Day **Physician** Frank W. Rodemeyer 14, 2000 March 7:35 p.m. /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth 9-29-25 | 9. Birthplaca (State or Foreign (Month, Day, Year) | Dec. 29, 1925 | Baltimore, Md. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 10 M 20 F 74 Yrs. 219-18-5992 Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Md. N/A Baltimore City Director 10g. Citizen of Whet Country? 10e Street and Number 10f. Zip Code ò 6400 Laurelton Avenue 21214 United States Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien Black, White, etc. 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Never Merried 2 Merried 1 X Yes 2 □ No If Yes, Give WW II Year or Dates: WW II Baltimore, Maryland 21215-0020 1 ☐ Yes 2 Ø No Specify: White Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) Self-Employed Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumeme) Be 2 should be fi and Mental F Graham Rodemeyer Mary Crosbie Pages 1 and 2 should nent of Health and Men 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stele, Zip Code) Bruce Rodemeyer (Son) 530 Walters Mill Road ForestHill, Md. 21050 Item 27 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removel from State 3/18/00 4 □ Donation 5 □ Other (Specify) Sacred Heart of Jesus Baltimore Maryland 22. Name and Address of Fecility 21. Signeture of Funeral Service Licenses Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 23a. Pert1. Enter the disease, or complications that causes the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or haart fellure. List only one cause on according. Approximate Intarval Between Onset end Deeth **Physician** /Medical Immediate Causa (Final disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequenca of): Physician/Medical Due to (or es e consequence of): Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wera autopsy findings available prior to completion of cause of death? Rodemeyer 24a. Was an autopsy performed? 1 Yes 2XNo 1 ☐ Yes 2 ☐ No certificate Vital Attending Physician: Be 25. Was case referred to medical 26. Placa of Deeth (Check only ona) Other: 4 Nursing Home 5 Residence 6 Sothar (Specifical) 1 Yas 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? Division 5 Pending investigation Neturel death. 1 Yes 2 No 2 ☐ Accident after deat Director: 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At home, ferm, atreet, factory, office building, etc. (Specify) filled in by 4 Homicide ò 24 hours Certifying Physician: To the best of my knowledge, daeth occurred at the time, data end place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, end dua to the cause(s) end menner stated. Medical 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of confine 29c. License number my 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) . R. Te. 6 Parac 670 31. Data filed (Month, Day, Year) 32. Registrar's Signature State 16 Registrar MAR **DHMH 16 Rev 6/95**

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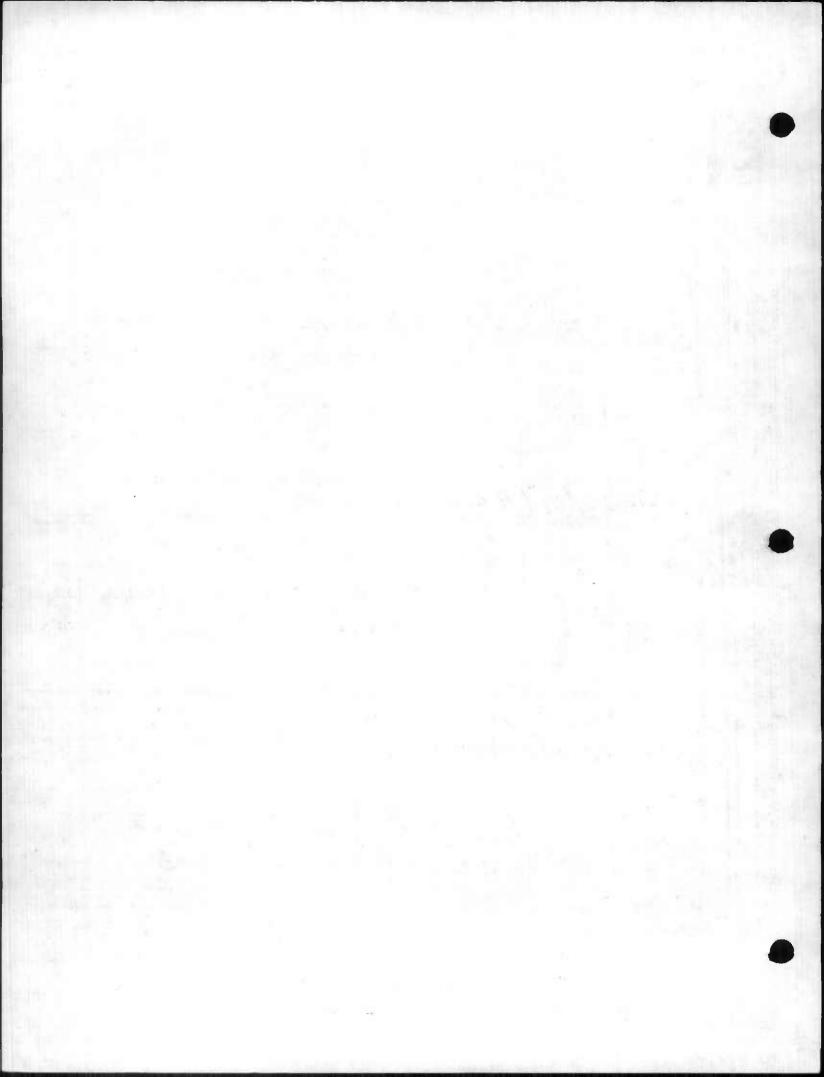
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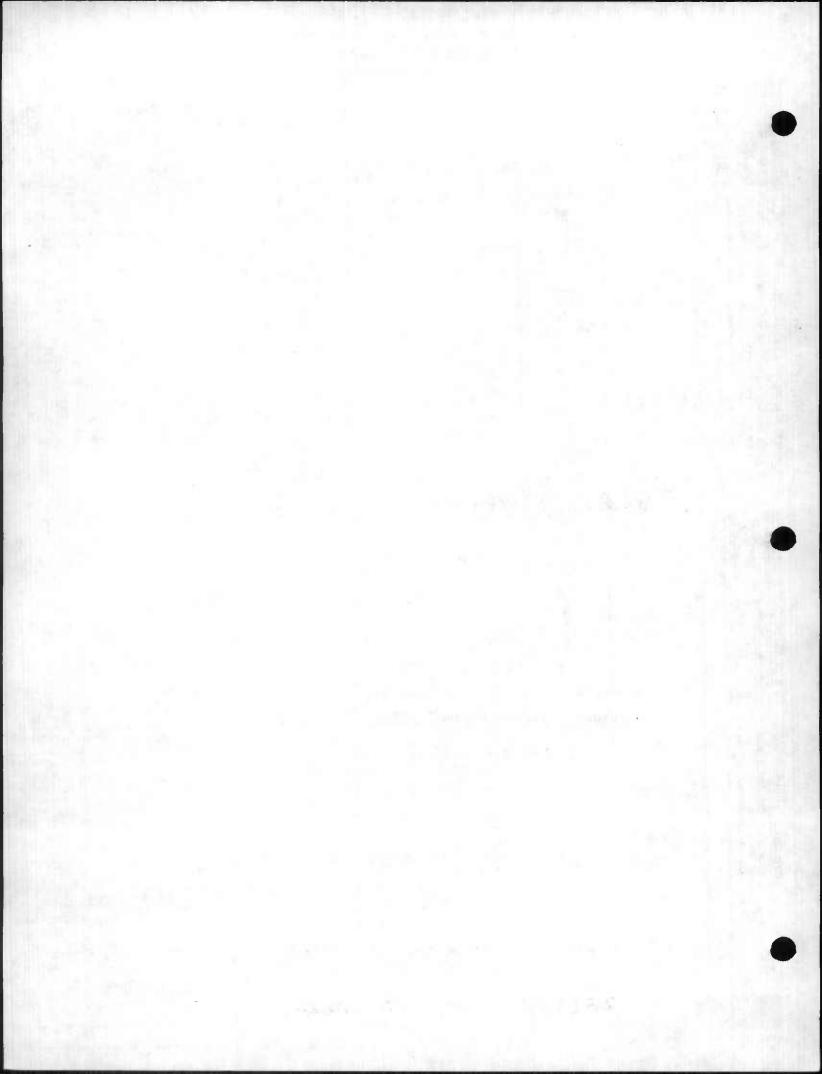
			Certificate of	Death	Reg. No.	00000
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Examiner Funeral Director	4a Facility Name (If not institution, git Lorien Nursing H 5. Social Security Number 6. S 215-22-4583	ome	rs. last birthday) If Under 1 Year Yrs. Months Days	Hours Min. (Month	Н	of Death IOWard 9. Birthplace (State or Foreign Country) MD
	Usual Residence of Decedent 10a. Stete 10b. County	ward 10c. 0	City, Town or Location Columbia	1 1100 2	.5, 1/20	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
vith the M t or 28a-f be notified	10e. Street and Number		10f. Zip Code		10g. Citizen of V	3883
11215-U020 within 72 hours after death with the Menyland see. then "natural", or items 23s or 28s-f show the Medical Examine must be notified at symmetric than a Director.	6334 Cedar Lane 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 X Yes 2 □ No If Yes, Give Yeer or Dates:		21045 Hispanic Origin? (Specify Yes or an, Mexican, Puerto Rican, etc.) Specify:		A e-American Indian, ck, White, etc.
iled within 72 hours at Mylene. Whor than "natural", or my it a Males Erm	15. Decedent's E (Specify only highest gra Elementery/Secondary (0-12)	ducation ade completed) College (1-4or 5+) +5	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire technica	pation during most of working of) 1 writer		usiness/Industry
wid be file Mental Hy inked other ritic event.	17. Father's Name (First, Middle, Last			18. Mother's Name (First, Mic Sarah Merv		99)
s 1 and 2 sho of Health end Nem 27 is m other traum	19a. Informent's Neme/Relationship (David Burnell/ne			rand Number or Rural Route No rick Ave Silve		
emit. Peges 1 a Department of Has mportant: if Nem iny injury or othe	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ 4 ፟ □ Donation 5 □ Other (Special	Removel from State	Place of Disposition (Name of cemetery, crematory or other pla	Date	20c. Location -	City or Town, State
permit. Pege Department of important: If any injury or once.	21. Signature of Funeral Service Lice	Vade Director	r State Anat Baltimore,	Sony Board 655 MD 21201	W. Balti	more Street
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aw requ	LARGECELL	LYMPHOM	A. BCELL	TYPE. 24a. P	Vas an autopsy enformed?	24b. Were autopsy findings aveilable prior to complation of cause of death?
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To the Hospital or within 24 hours afte to the Funeral Director Completely filled in Medical Cert			nowledge, death occurred at the ti netion and/or investigation, in my o			
To the To the Comple	29b. Signature and title of certifier	u Marly	9 MD D31		29d. Date signer 0 2 2	d (Month, Day, Year)
		RILS 2 KN	IOU NORTH DR	· columbia	ND 210	45
State Registrar	31. Dete filed (Month, Day, Year) MAR 1 6 20	32. Registrar's Sign	gature B. Spork	2		



State of Maryland / Department of Health and Mental Hygiene

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dical - liner	4a Facility Neme (If not institution, gi	ive street end number)	17.4		-	b. City, Tov	wn, or Locatio	n of Death	4c. County	of Death	
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al I		Sax 7. Aq	e (In yrs. last bi		r 1 Yaar	If Under 2	24 Hrs. 8. D	ate of Birth		9. Birthpl	aca (Stete or Foreig
-	217-76-1357 Usuel Residence of Decedent	18 M 2□F	87	Yrs. Months	Days	Hours	Min. (/	rch 8,	1912	Count ur	iknown
-	10a. Stete 10b. County		10c. City, Tow	n or Location				100		10	d. Inside City Limit
Director	MD N,	/A		Baltimo	re						1X Yas 2□N
	10e. Street and Number 3907 Barrington	Road		10f. Zi	p Code 21	207			g. Citizen of W	hat Count	ry?
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-	Sinai Hospital		Tank The			vedere					
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	21. Signeture of Emeral Spruce Lion Ronald S	Wade, Dir	ector	22 Neme e State		_	Board (555 W.	Baltin	nore	Street
+	23a. Part1. Enter the disease, or con	nplications thet caused	I tha death. Do					piratory erre	st,		Approximate
	ehock or heart feilure. List only	y one ceuse on each lii	ne.								Onset end Death
	Immediate Cause (Final										
	disease or condition resulting in death)	a. Pr	VEHMO	NIA							
			Due to (or es a	consequence of):						
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Ear	Sequentially list conditions,		Dua to (or es a	consequence of	:						
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Physician/	that initiated avants resulting in deeth) Last	d	ut not resulting	in the underlying	cause giv	en in Pert I.		23b. Did tol	1		the causs of death
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by Physician/	Part II. Other significant conditions	contributing to death by	HLUDE	in the underlying	cause giv	en in Pert I.			autopsy	3 Prot	eably 4 Unkno
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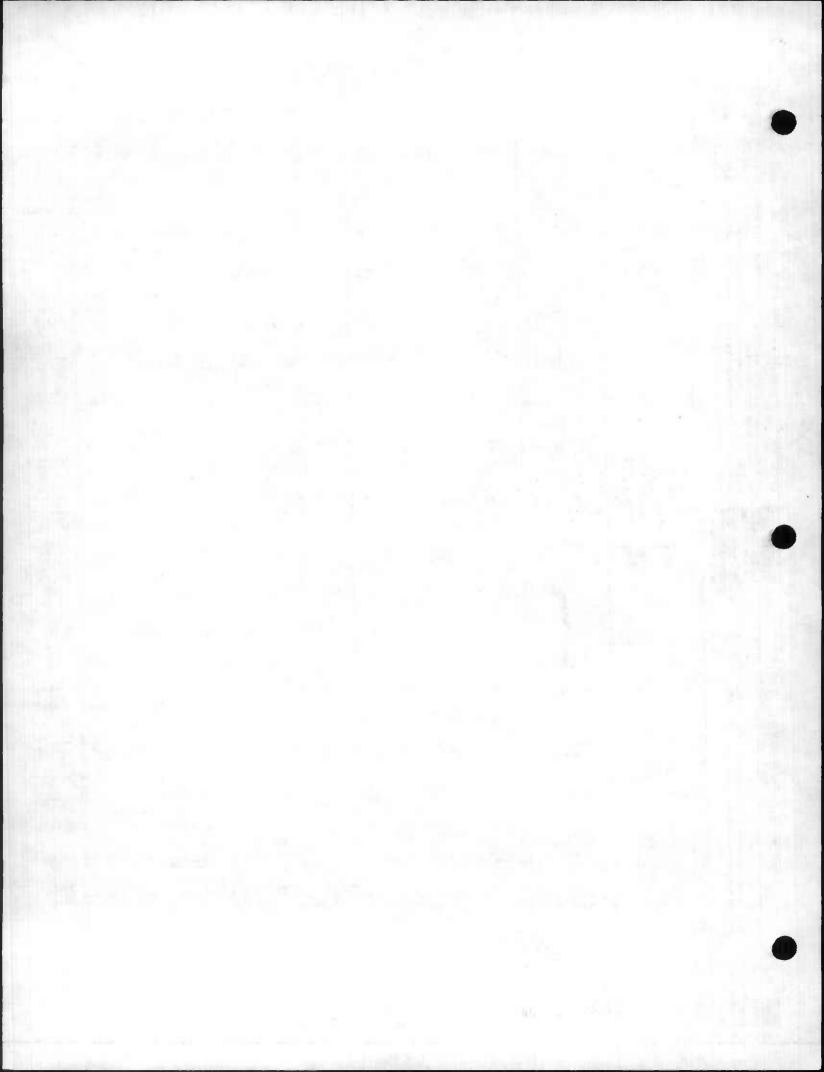


Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Physician Month Day Year TRMA W. SELBY MARCH 7:30 P.M. 5 2000 /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ROSe If Under 24 Hrs. IA FRANKlin SEVARE CenTer dAle 140501 LIMORE 5. Social Security Number If Under 1 Year Birthplace (State or Foreign Country) MD Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 F Months 77 217-12-3000 Director Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore 7.28a-f Baltimore 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 급 23s or 21234 IISA 9317 Shady Creek Way Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Berra. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 8 altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white p 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) microfilm government unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental is marked Viola Bartell 2 Aquilla Walker 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9317 Shady Creek Way Baltimore, MD Gail Diegel/daughter mportant: If Item 27 20b. Plece of Disposition (Name of 20e. Method of Disposition Dete 20c. Location - City or Town, State cemetery, crematory or other plece) 1 Burial 2 Cremation 3 Removal from Stete
4 Donation 5 Other (Specify) 3 Plane and Africa Collin Board 655 W. Baltimore Street Roberd S. Wades Director 21201 Baltimore, MD 23a. Pyrit. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory arrest, short, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Finel diseese or condition resulting in deeth) DAYS **Examiner** Examiner CEREBRO VASCULAR Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760. Physician/Medical the Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. by The law requires 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed 24a. Wes an eutopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? After 1 Neturel 2 Accident 5 Pending investigation s after death. 1 TYes 2 □ No 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homlcide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) end menner stated. 29a, Certifier within 2 To the the th 29b. Signeture end title of certified 29c. License number 29d. Dete signed (Month, Day, Year) 0 HU052365 30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print) FRANKlin Spuace DD. BAITIMORE, MARY LAND DR. Ronald 9000 JeffReys 32. Registrar's Signeture State Genera Registrar

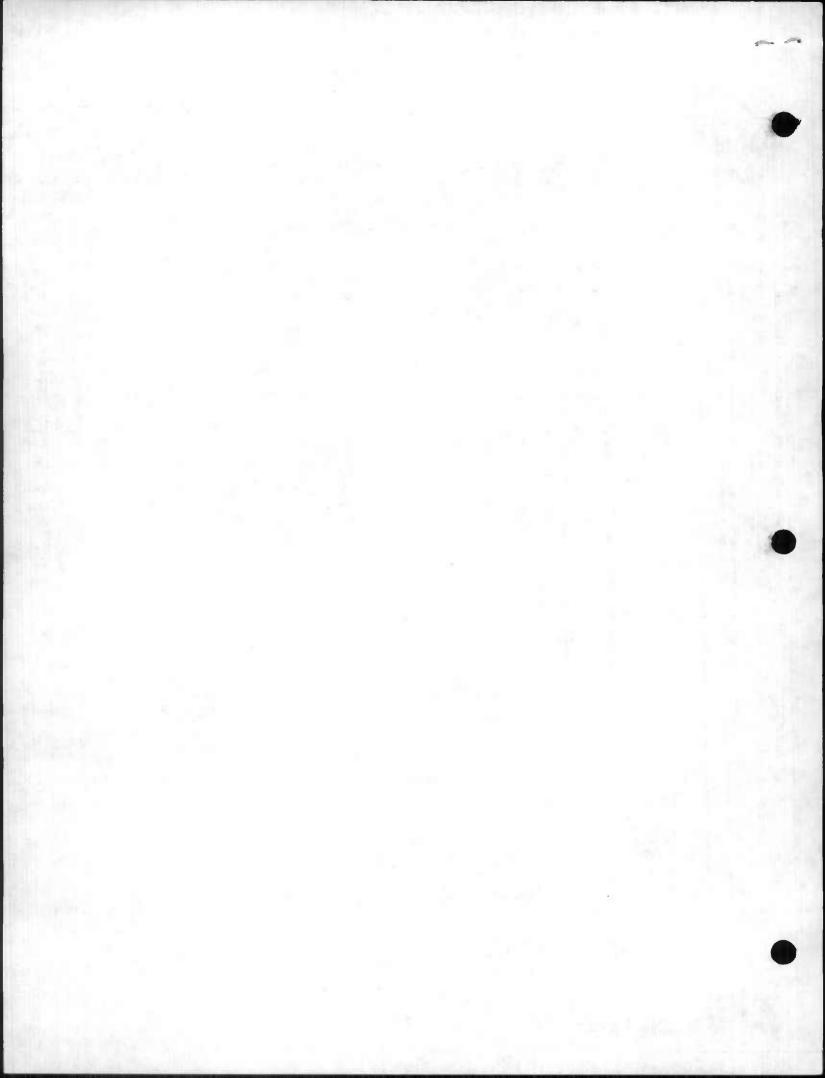
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State of Maryland / Department of Health and Mental Hygiene 00 08865

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ioer must	11. Marital Status	12. Was Decedent Evar in U, Armed Forces?	S. 13. Was Decedant of	Hispanic Origin? (Spec ban, Maxican, Puarto F	cify Yes or No-	14. Raca - Americ Black, White,	
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nt, the Medical of Completed	15. Decedent's Ed	ucation	16a. Decedent's Usual Occi	pation during most of working	16b. Ki	nd of Business/In	dustry
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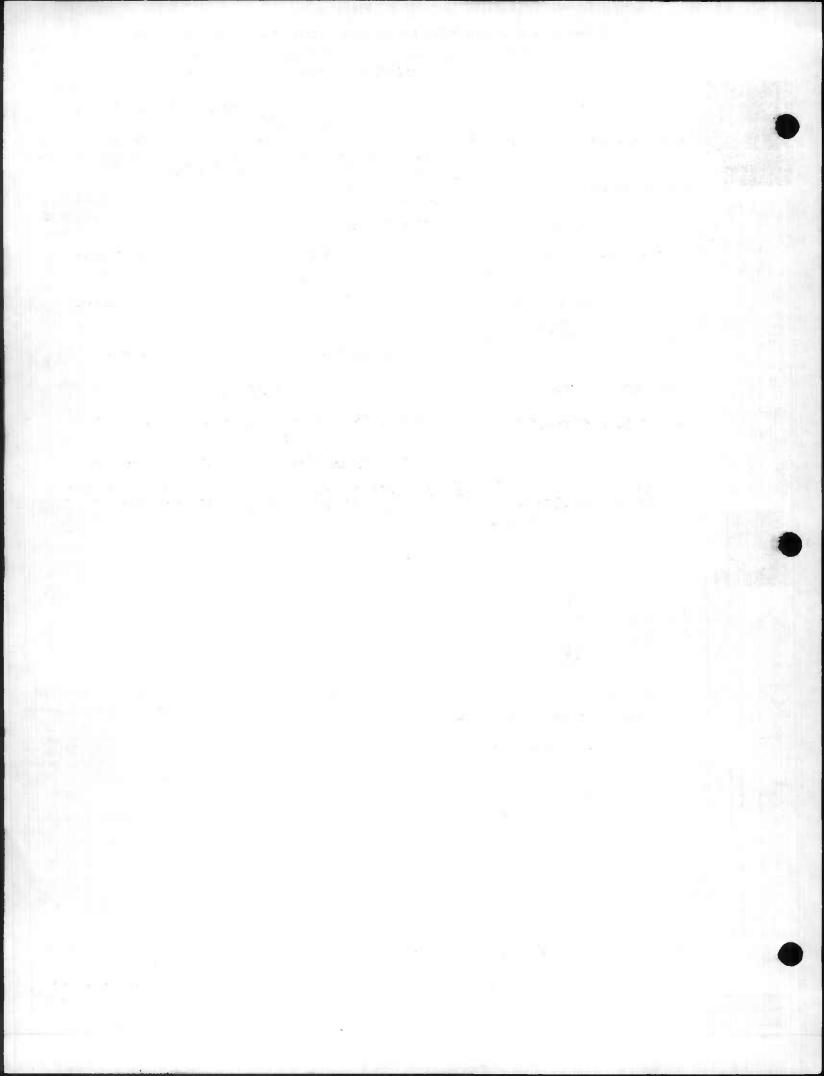
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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		1 Decedent's Name	/Eiret Middle I	net)		061	lilicate c	Dealli	O Date of D	Reg. No.	- 1	O. Time of Death
Physiciai /Medica	al	1. Decedent's Name	Eliza	beth An		hmer			2. Date of De Month March	Dey 14	2000	3. Time of Death 2:00am
Examine		4e. Fecility Neme (II Howard Co						4b. City, Town,	or Location of Deal La		y of Death Howard	
uneral rector	7	5. Social Security N 218-26-5	5423	Sex 1□M 2DXF	7. Age (In yrs. 71	last birthday) Yrs.	If Under 1 Ye Months Day		lin. (Month, D	rth ay, Year) 21,1928	9. Birthplac Country MD	ce (State or Foreig y)
wow #		Usuel Residence of 10a. Stete	10b. County		10c. Ci	ity, Town or Lo	cation				100	d. fnside City Limit
28a-f show	ecto	MD 10e. Street and Nun	Howard	d	1	Ellicot	t City			10g. Citizen of	Man County	1 □ Yes 2% N
23a or		8618 N. H		rt				.043			ed Stat	
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ther	-	Joseph E.		er/Sr.	20h I		N. Bali		Cllicott (20c. Location		
Important: If item 27 any injury or other ti pnce.		Buriel 2	Cremation 3 [5 Other (Speci		State	cemetery, crem	natory or other p	olace)	3-17-200			
eny injury	1	21. Signature of Fur	neral Servica Lica	lln	11)	/ Ha		Witzke's	Family Pike El			
	al Examiner	Sequentially list cor if any, leeding to im cause. Enter Under Cause (Disease or i	nditions, mediate rlying njury	b		or es e conseq or as a conseq						
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5 7 .		27. Menner of Death 1 MNeturel 2 □ Accident		28a. Date (Mon	of injury of, Day Year)	28b. Time of Injury	28c. ir	ijury et Vork?		how Injury occur		
completely filled in by the funeral	Sering.	3 ☐ Suicide 4 ☐ Homicide	8 Could not to determined	28e. Place	of Injury - At h ing, etc. (Speci	ome, farm, stre	eet, factory, office	×a.		(Street and Num. own, State)	ber or Rural F	Route Number,
completely filled in	edicai	29a. Certifier (Check only one)	1 Certifying Pi 2 Madical Exa	minar: On the b	best of my kno asis of examine ner stated.	owledge, death ation end/or inv	occurred at the estigetion, in m	time, dete end pla y opinion, deeth o	ece, and due to the courred et the time,	ceuse(s) and m , date and place,	anner as stat and due to th	ed. ne cause(s)
comp		29b. Signature and	title of certifier	mi	Pers	- mo) 17821		29d. Date signe		
State		30. Name and eddre WARRE 31. Date filed (Mont.)	v m	Ross,	se of death (Iter	m 23a) (Type, F 4801	Print) Docsey	Hull C)rwe,	Ellica	# Ci	ty mi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14, 2000 4c. County of Deeth Anna M. Stokes parch on of Dep 4a Facility.Name (If not institution, give str 4b_City, Town saltimore 1/ano 8. Date of Birth (Month, Day, Year) If Unde If Under 24 Hrs. 7. Ann /In was last hirthday) Birthplace (State or Foreign Country) Days Months Hours 1□M 2♥F 81 578-20-6147 4-14-1918 Va Usual Residence of Decedent 10e. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1XX es 2 □ No Md N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2716 Ellicott Drive 21216 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Rece - American Indien, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married 1 Yes XXXVIO Specify Specify: Black 3/Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Private Duty Self Employed Nurse 12th grade 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) John C. Flood Bettie A. Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Stokes-Daughter 2732 Sweetwater Ct Forestville, Md 20747 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremetion 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery B-18-00 Baltimore, Md 22. Name and Address of Facility 21. Signature of Funeral Service License March F/H West 4300 Wabash Avenue Baltimore, Md 21215 23a. Pert Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Due to (or as a consequence of): Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? OBStructive 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? as cular eas 2 No 1 Yas 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 1 (2 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Tyes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

The law requires that the deeth certificate be executed physician s the buriel Box 68760, 800 P.O. Records, certificate has Division of Vital or Attending Physicien: funeral director, After this efter death. filled in by within 24 hours e Hospital

Physician

/Medical

Examiner

Funeral

Director

"natural", or flams 23a or 28a-f show solical Examiner must be notified at

permit. Peges 1 and 2 should be filed within 72 hr. Department of Health and Mental Hyglene. Important: If tem 27 le marked other than "natuneny injury or other treumatic event, the Medical page.

Physician /Medical

Examiner

Examiner

Physician/Medical

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Be Completed

Certification: To

Medical completely

29a. Certifier

(Check only one)

29b. Signature and title of certifie

Baftimore,

Director

Funeral

by

Completed

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the Meryland

State Registrar

DHMH 16 Rev 6/95

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32. Registrar's Signature

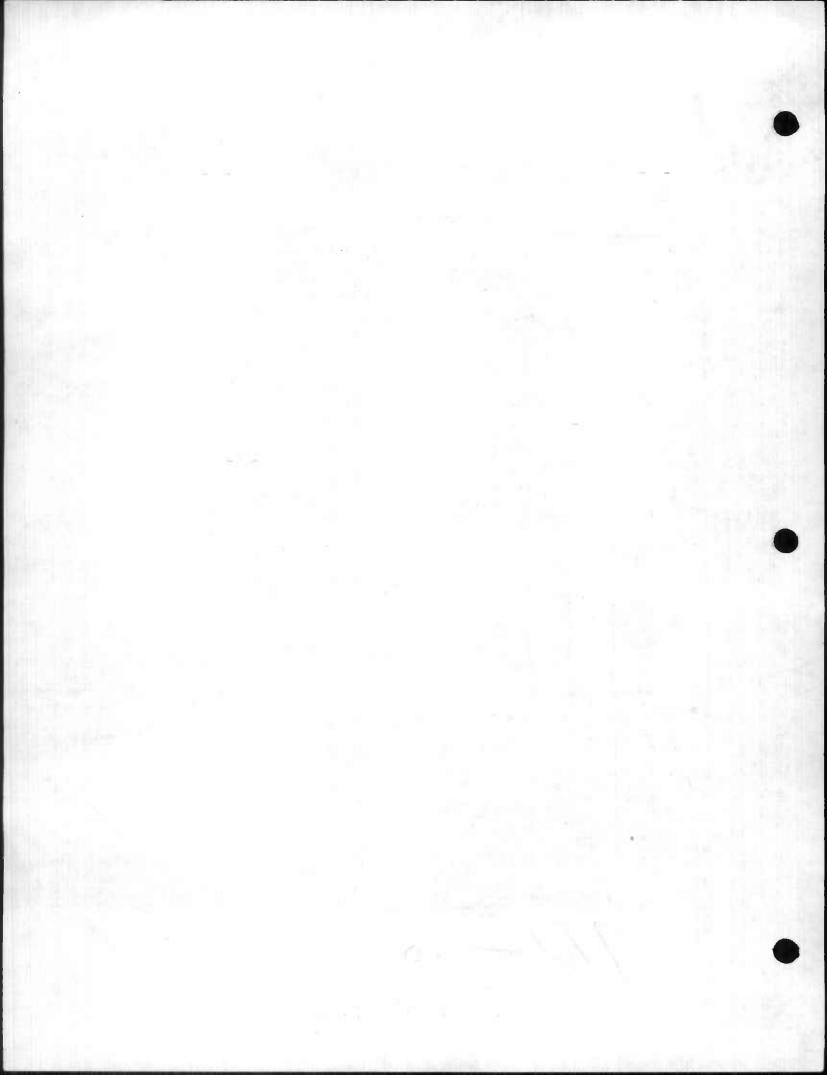
who completed cause of death (Item 23a) (Type, Print)

iner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

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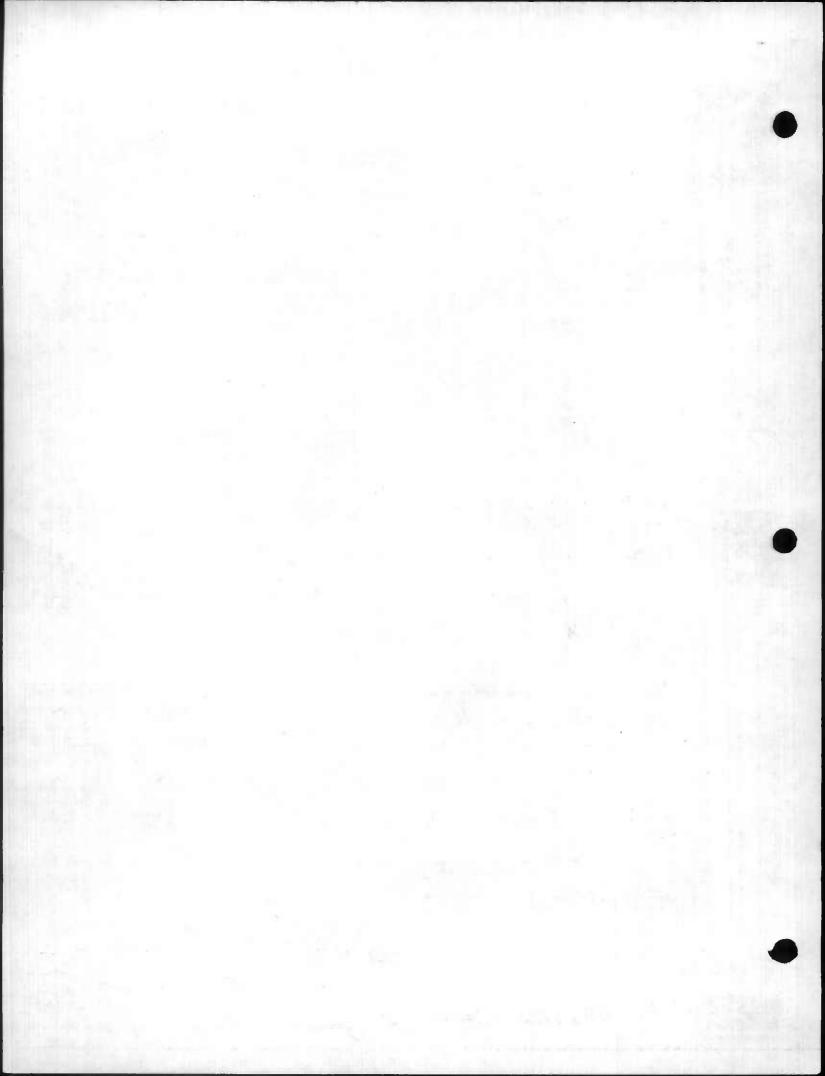
1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the course of the time.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

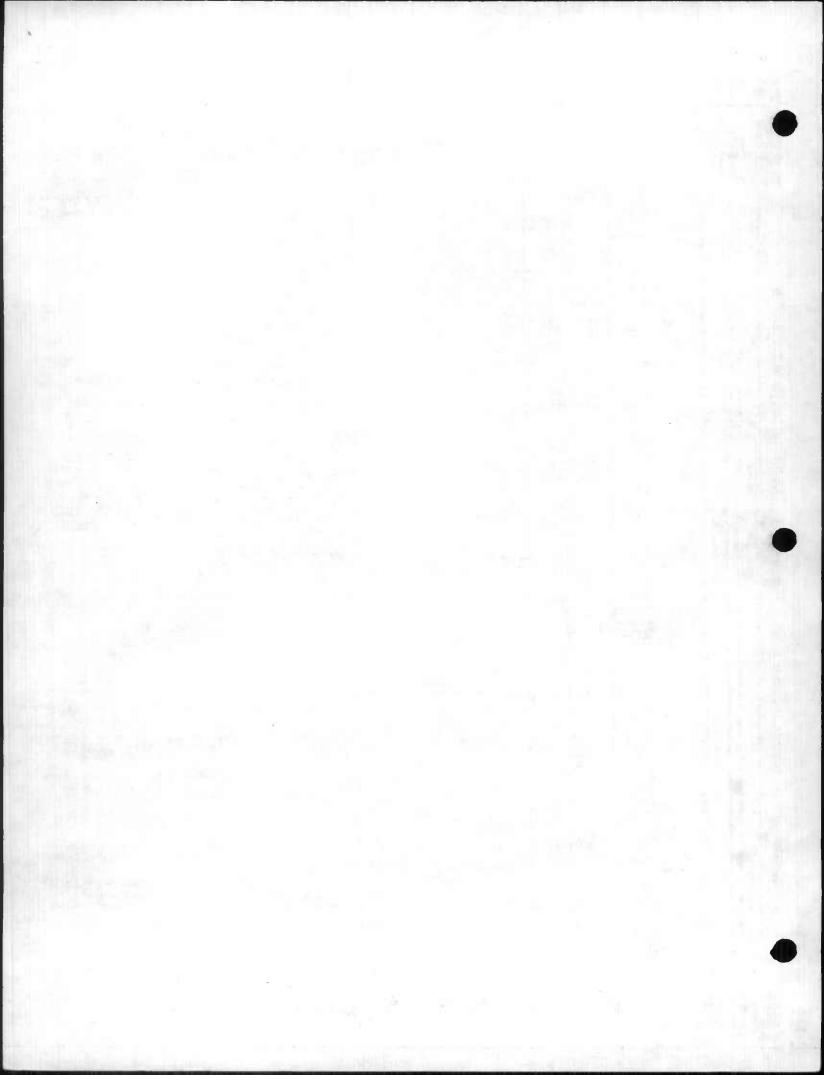
_	1. Decedent's Name (First, Middle, Last)	e of Death	Reg. No.	3. Time of Death
Physician	Matthew F. Siran		Month Dey Ye	1815
/Medical Examiner	4a Facility Name (If not institution, give street and number)	4b. City, Town, or Location		Deeth
LAUTHITE	Harmony Hall Nursing Home	Columbia	Howar	:d
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under		Dete of Birth 9.	Birthplece (State or Fore
Director	408-09-4381 1 M 2 F 84 Yrs. Months	Deys Hours Min. (March 3, 1916	Pennsylv
1.	Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location			10d. Inside City Lin
d'alto	MD Prince Georges Seabrook			1 ☐ Yes 2 X ☐
or 28s-f s be notified Director	10e. Street and Number 10f. Zip	Code	10g. Citizen of Wha	t Country?
	9210 Sheridan Street	20706	USA	
Etaminer in by Fune	11. Meritel Stetus 1 Never Married 2 Merried 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Merried 12. Was Decedent Ever in U.S. If Yes, specific yes, yes, yes, yes, yes, yes, yes, yes,	tent of Hispanic Origin? (Specify ify Cuban, Mexican, Puerto Rica	Yes or No- nn, etc.) 14. Race -/ Bleck, V Specify: To	American Indian, White, etc. Vhite
leal lead	15. Decedent's Education 16a, Decedent's Usua	I Occupation	16b. Kind of Busin	ess/Industry
rgiens. er than 'netur t. the Medical.	Elementery/Secondary (0-12) College (1-4or 5+) life. DO NOT us		NCA	
Co. The		. Analyst	NSA	
ever Be	17. Father's Neme (First, Middle, Last) John Siranovich		rst, Middle, Maiden Sumeme) a Dekanic	
d Men		(Street and Number or Rural Ro		te Zin Code)
27 is r trau	Kathleen Coleman daughter 7329 Green	Oak Terrace La	nham, Maryland	20706
Head of the search	20e. Method of Disposition 20b. Plece of Disposition (Ner	ne of D	Pete 20c. Location - City	y or Town, Stete
H:H	1 □ Burial 2 (XCremation 3 □ Removel from Stete Baltillion of the Washington S □ Other (Specify)	ematory 3-1	3-00 Laurel, N	Marvland
Total .	21. Signeture of Funeral Service Licensee 22. Name an	d Address of Fecility	1	
o attending physician and the burial-transit and the burial-transit and the burial-transit and the biclan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	cult Accio	dent	1980
physicians the burner of the b	Cause (Disease or Injury that initiated events resulting in deeth) Last C. Due to (or as a consequence of):			
the atterned for hed for ysicia	Pert ft. Other significant conditions contributing to death but not resulting in the underlying of	ause given in Pert I.	23b. Dfd tobacco uss contril	buts to the cause of de
detac detac	Hypertusion		1 Yss 2 No 3	Probably 45 nk
2 shoul	7,		24a. Wes en autopsy performed?	4b. Were eutopsy findin available prior to completion of cause of death?
page Com			1□Yes 2000	1 □ Yes 2 0
certificate rector, pag	25. Wes case referred to medical examiner?	26. Place of Deeth (C)	heck only one)	
를 를 다	1 Yes 2 No Hospitel: 1 Inpatient 2 ER/Outpatient 3 DC		5 ☐ Residence 6 ☐ Other (Specify)
After funeration:	1 de la company	Work?	. Describe how injury occurred	
or death ector: by the	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of fnjury - Al home, farm, street, factory building, etc. (Specify)		Location (Street and Number of City or Town, State)	or Rurel Route Number,
in 24 hou he Funer pletely fill edical	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deeth occurred 2 Medicat Examiner: On the basis of examinetion and/or investigation and menner steted.	et the time, dete end plece, end on in my opinion, deeth occurred et	t the time, dete end plece, and	due to the cause(s)
To the company of the	296. Signature and title of certifier 296	License number	29d. Date signed (A	Aonth, Day, Year)
~ (Doing & Briefler and	DO0375	Mars	ch 8,2
2	Name and address of person who completed cause of death (Item 29e) (Type, Print) 57 WA LWZ HZAITH CAAR	8827 10	Wmbi'A DPKWY Swi	les Column
State Registrar	31. Date filed (Month, Def. Year) MAR 1 6 2000 Segue 4	1		2104



State of Maryland / Department of Health and Mental Hygiene 00 08869

	IOHN M. SIMMONS		Certific	ate of	Death		Reg. No.		00000
	1. Decedent's Nama (First, Middle, Las	(t)				2. Date of De Month	eath Day	Year	3. Time of Death
sician edical	JOHN M. SIMMON	S				MARCH	12,	2000	2130 PM
ner	4a Facility Nema (If not Institution, give	street and number)			4b. City, Town, o	r Location of Deat		y of Death	
	UNIVERSITY HOSPI	TAL SHOCK TRA			BALTIMO		M		
	5. Social Sacurity Number 215-06-4421. Usual Residence of Decedent	7. Age (In yrs	Mont	hs Days			rth ay, Year) -80		laca (Stete or Foreign stry)
	10a. Stete 10b. County	10c. C	city, Town or Location					1	0d. fnside City Limits
Director	MD N/A	E	BALTIMORE						1 Yes 2 No
ai Dir	10e. Street and Number 2325 W. LAFAYE	TTE AVE	101.	2 1. 2	1.7		10g. Citizen of	S · A ·	try?
by Funeral	11. Marital Status 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 No If Yes, Give Year or Detes:		37	Hispanic Origin? (ban, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		ce - Americ ock, White, fy: BLA(etc.
eted	15. Decedent's Ed (Specify only highest great	ucation de completed)	16a. Decedent's U	Isual Occu	pation during most of w	orkina	16b. Kind of E	Business/Inc	Justry
Completed	Elementary/Secondary (0-12) 1. 2	Cotlege (1-4or 5+)	lite. DO NO	Tuse retire	ed)				
Bec	17. Father's Nema (First, Middla, Last)				18. Mother's N	ame (First, Middle	, Maiden Sumai	me)	
0	JOHN SIMMONS				MICHEI	LLE WHA	LEY		
	19a. Informent's Name/Reletionship (7	ype, Print)	19b. Mailing Add	ess (Stree	t and Number or I	Rural Route Numb	er, City or Town	, State, Zip	Code)
	MICHELLE SIMMO	NS, MOTHER	2325 W.	LAF	AYETTE	AVE, B	ALTO.	MD 2:	1217
	20e. Method of Disposition		Place of Disposition (cemetery, cremetory	Name of or other pla	ace)	Date	20c. Location	- City or To	wn, State
	4 Donetion 5 Other (Specify		BUTUS ME	MORI	AL	03-17-	OO ARB	UTUS	, MD
	21. Signature d'Euneral Service Licere	40			ess of Fecility	HOME	7.1		
	1 NET	(UNERAL ERTY HO		E DAT	то мі	0 21207
г	23a. Part1. Enter the diseese, or comp shock, or heert feilure. List only of	lications thet caused the dee	eth. Do not enter the r	node of dy	ing, such es cerdi	ac or respiratory	errest,	TO.MI	Approximate
n	snock, or neer reliure. List only o	one cause on eech line.							Onset and Death
	Immediete Cause (Final disease or condition	· GUISHOT 1	DOWN T	D BA	u or	Wor		- !	
	resulting in death)		(or as e consequence			21		1	
ner									
Examiner	Sequentially list conditions, if any, leeding to immadiate cause. Enter Underlying Cause (Diseese or injury	b. Due to	(or as a consequence	of):					
Medicai	resulting in death) Last	Due to (or es a consequence	of):					
2101								ĺ	
Physician	Part If. Other afgnificant conditions co	ntributing to death but not re	sulting in the underlying	g ceuse gi	iven in Part I.	23b. Did	tobacco use co	ontribute to	the cause of death?
Dy PH						10	Yes 2 No	3 Prot	bebly 4 Unknown
Completed						24a. Was perf	an autopsy omed?	CO	ere autopsy findings allable prior to mpletion of cause death?
EO						ter	Yes 2□No	15	Hes 2 No
BeC	25. Was case referred to medical				26. Place of D	eath (Check only	one)		
TOE	examiner? 1 Yas 2 No	Hospitel: 1 Inpatient 2	ER/Outpatient 30	DOA O	hor	Home 5□ Res		her (Specif	v)
	27. Menner of Death	28a. Dete of Injury (Month, Day Year)	28b. Time of	28c. Inju	iry at	28d. Describe	how injury occu	rred	
atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	3-12-00	20:37 M	10	Yes 2 No	Sursi	our W	JDS S	HOT.
Certification:	3 Suicide 6 Could not be determined	28a. Plece of Injury - At I building, etc. (Spec	nome, ferm, street, fed	tory, office		28f. Location (City or To		ber or Rura	I Route Number, W
edical C	(Check only 2 Medical Exam	alcian: To the best of my kn	owledge, death occur	ed at the ti	ime, date and place	e, and due to the	cause(s) and m	nanner as si	lated.
Med	one)	and manner steted.		00- 1:			201 0-1	d (0.4	Day Vand
-	29b. Signeture and title of cartified	elfre o	h.	29c. Licen	OCME		29d. Date signal MARCH		
	30. Name and address of parson who c							100	
	MD MD ONDS 1	S. Kossel 11:	l Penn Str	eet,	Baltimor	e, Maryl	and 212	01	
State	31. Dete filed (Month Par Year) 6 2	32. Registrar's Sign	grure G.	don	Kal				

DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene

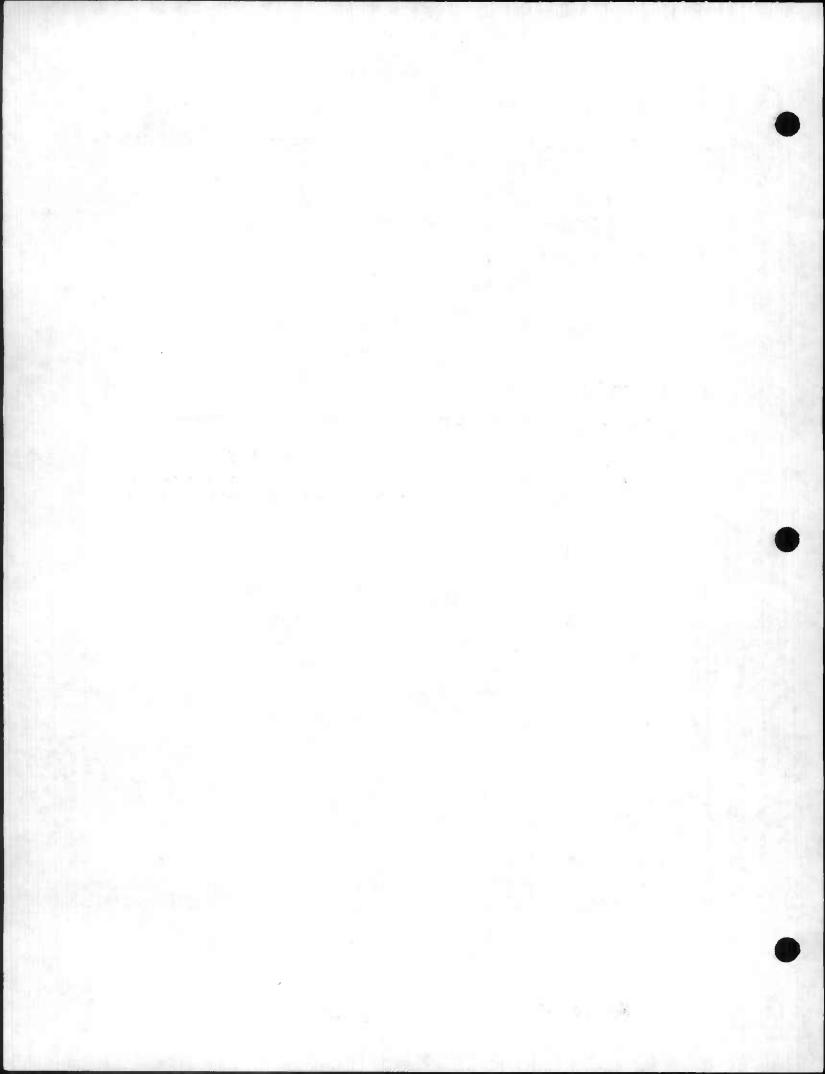
	1. Deced	ent's Name	e (First, Middle	e, Last)									2. Date of D		11		3. Time o	Death
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edical miner			not institution,					-		4	b. City, To		ocation of Deal	-	c. County			
	416	Sacr	ed Hear	rt La	ane					1-	eiste					timo		
	220-0	Security No.	66	6. Sex	M 2X0 F	7. Age (in yrs. les 85	t birthdey) Yrs.	Months	1 Yeer Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bi (Month, D Sept.	19,	1914	9. Birth Cou	place (State ntry) RI	or Foreign
	10a. State		10b. County			1	Oc. City, 1	Town or Lo	cation	-							10d. Inside (ity Limits
Director	MD		Baltim	more			Re	eiste	rstow	n							1 🗆 Yes	2 No
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í	106	Broo	kbury [Driv	e Ap	t. 2	С			211					USA			
į	11. Merita				2. Wes Dec	orces?	er in U,S.	13.	Wes Dece If Yes, spe	dent of H cify Cube	lispanic Orig	gin? (Spon, Puerto	ecify Yes or N Rican, etc.)	0-		e - Ameri ck, White,	can Indien, etc.	
29.5	1		ed 2 Marrid		1 Tes If Yes, Gi Yeer or D	ive			1□ Yes	2∕□ No	Specify:				Specify	" Wh	ite	
none.		(Speci	15. Decedent'	's Educa	ition completed))		16a. Dece	dent's Usu kind of wo	al Occup	ation during most	t of work	ing	16b.	Kind of Bu	usin ess/i r	ndustry	
Completed	Elemen	ntary/Secon	ndary (0-12)		College (1)			NI -	- de la 11			
т.	17. Fathe	12 r's Name (First, Middle, L	Last)				rar	t Ow	ner	18. Mothe	er's Name	e (First, Middle				ng Co.	
990			rkins										strom					
			me/Relationsh	hip (Type	e, Print)			19b. Mailie	ng Address	s (Street			al Route Numi	per, City	y or Town,	State, Zi	p Code)	
	Patr	icia	M. Spa	mpir	nato [Daugh	iter	416	Sacr	ed H	eart	Lane	, Reis	ters	town	, MD	2113	6
	20a. Meth	nod of Disp					20b. Plac	e of Dispo	sition (Nemotory or o	me of other plea	ce)	1	Dete	20c.	Location -	City or T		
	04 6:						Lori	raine	Park	cen	netery	1 31	/18/00	MO	odlaw	VII , I'	ID	
		Kar	neral Service L	License	2	le	ne	E	Name at	Fune	ss of Facilit	lome	11824 Reist	Re	ister	stow	n Rd 2113	
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State Registrar

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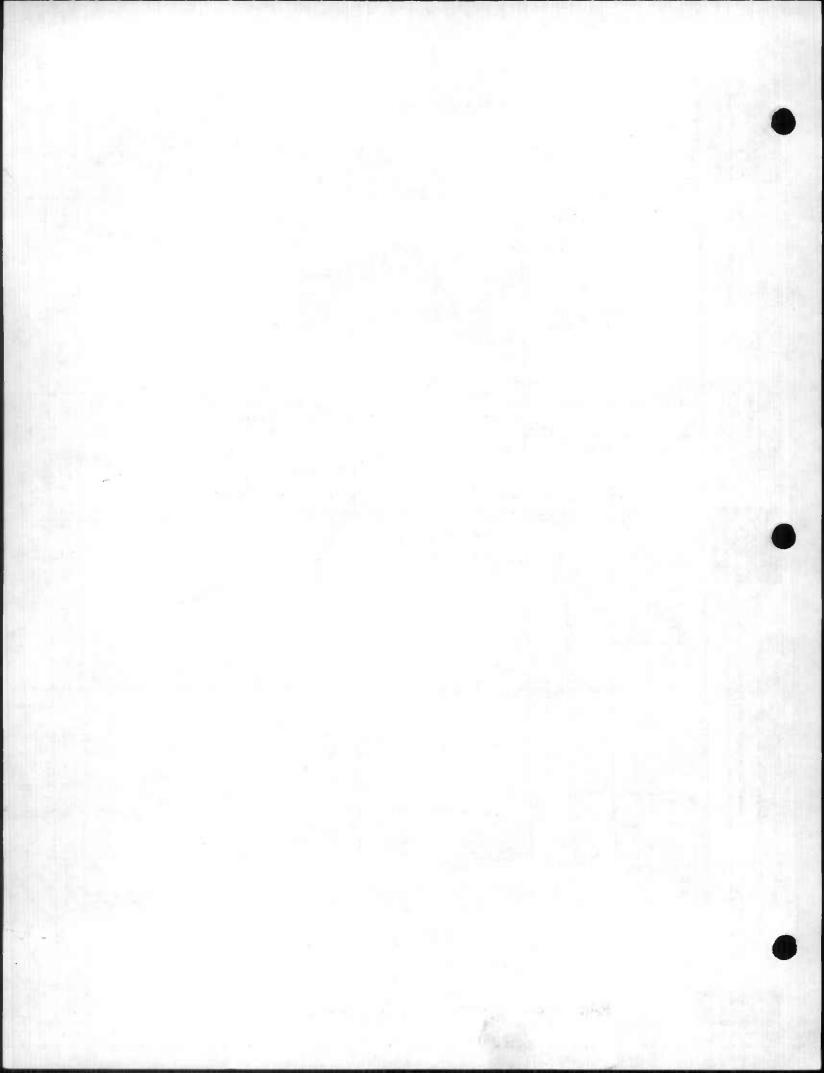
29c. License number

29d. Date signed (Month, Dey, Year)

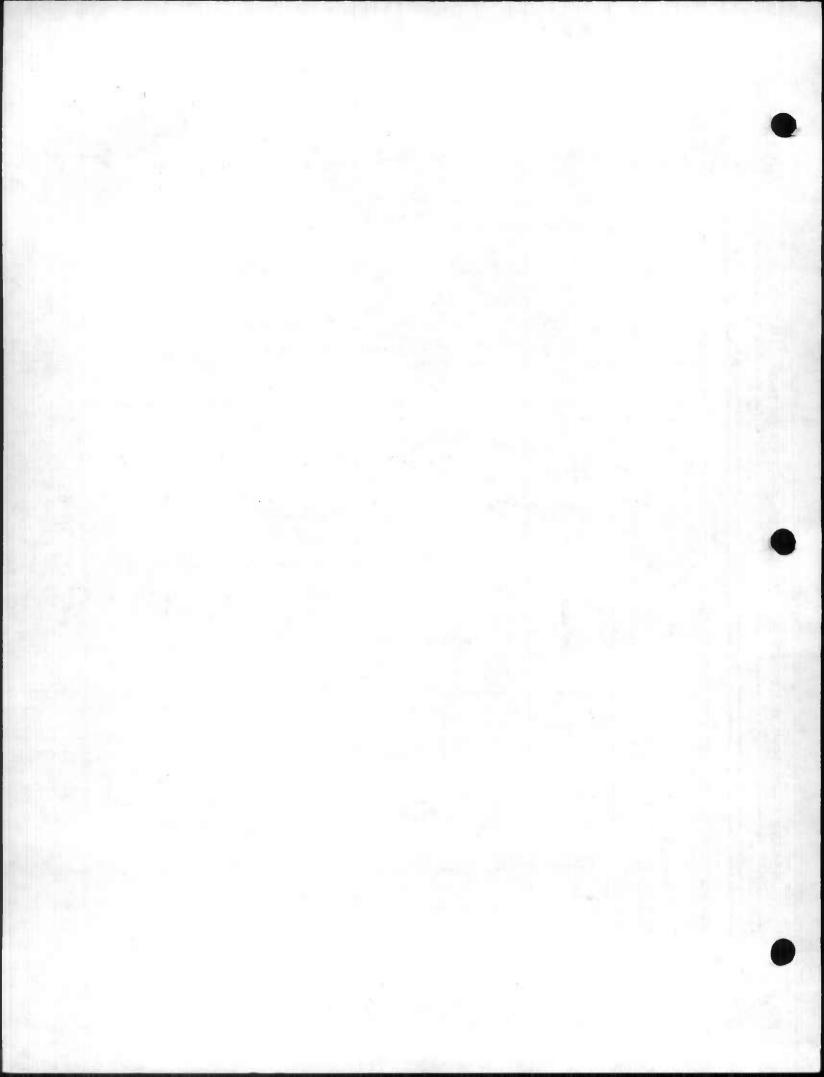


	State of Maryland / Department of Health Certificate of Deat	0.0	7 1
Physician /Medical	OOSCOIL II* LIELLEA	2. Date of Death Month Day Year March 14, 2000 9:25 at	
) Examiner	VA MEDICAL CENTER, FORT HOWARD, MD 21052 4b. City. FORT	Town, or Location of Death 1 HOWARD 1 HOWARD 2 HOWARD 3 HOWARD	
Funeral Director	5. Social Security Number 216-36-8656 Usuel Residence of Decedent 6. Sex 100 PT. Age (In yrs. last birthday) 6. Sex (In yrs. last birthday) 6. Sex (In y	der 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-8-39 8. Birthplace (State or For Country) Baltimore, N	neign 1d.
the Maryland 28a-f ahow notified at	10a. Stete 10b. County 10c. City, Town or Location	in 10d. Inside City Li	
O after death with the Maryle re Herra 23a or 28a-f sho miner marthe notified at Finneral Director	10e. Street and Number 12 Dockside Court	21811 United States	
Do urs	1 3 Widowed 4 Divorced Yeer or Deles: 1965 1 Yes 2 X No Special Yes 2		
	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Uphol steren		
Viand be fill Mental H Mental H integration of the control of the	17. Father's Neme (First, Middle, Last)	other's Name (First, Middle, Maiden Sumame) Mary Ann Gillooly	
other trauma	19a. Informent's Neme/Reletionship (Type, Print) John H. Tierney (Brother) 19b. Mailing Address (Street and Nurr 12 Dockside Court	,	
	20e. Method of Disposition 1 🖾 Burial 2 Cremetion 3 Removel from State 4 Donation 5 Other (Specify) 20b. Piece of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery	Date 20c. Location - City or Town, State 3/17/00 Baltimore, Maryland	
Baltim permit. Pa Departmen important: eny injury		Road Baltimore, Maryland 21214	
Physician /Medical Examiner	23e. Pert1. Enter the disease, or compliceliohs that caused the deeth. Do not enter the mode of dying, such shock, or heart feilure. List only one ceuse on each line. Immediate Cause (Finel disease or condition resulting In death) e. Lung Cancer with Metastasis Due to (or es e consequence of):	as cardiac or respiratory arrest, Approximate Interval Between Onset and Deatl 8 months	th
Geath certificate be assecuted eattending physician and of for use as the burial-transit sician/Medical Examiner	Cause (Disease or injury that initialed events Due to (or es e consequence of):		
S, P.O. Box 68 as that the death certification of the attending plus detached for use as the physician Medical physician	Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Par	art I. 23b. Did tobecco use contribute to the cause of de	with?
S, as the set bed by	- CONTROPHECITA	1 🔯 Yes 2 No 3 Probably 4 Unk	
De se		performed? available prior to completion of cause of death?	
yelclen: Tyelclen: Tis certificat director, pa	25. Wes case reterred to medical exeminer?	lace of Death (Check only one) Nursing Home 5 Residence 6 Other (Specify)	
ivision r Attending tar death. rector: After n by the fune	27. Menner of Deeth 1 Natural 5 Pending Investigation 3 Suicide 4 Homicide 4 Homicide 28a. Dele of Injury 28a. Dele of Injury (Month, Dey Year) 28b. Time of Injury at Work? 1 Yes 21 28a. Dele of Injury (Month, Dey Year) 28b. Time of Injury at Work? 1 Yes 21	28d. Describe how injury occurred □ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To the Hospital or within 24 hours at within 24 hours at completely filled is completely filled is Medical Cel	29e. Certifier (Check only one) Certifying Physician; To the best of my knowledge, death occurred at the time, date considered in t	and place, and due to the cause(s) and manner as stated. death occurred et the time, date and place, and due to the cause(s)	
N Suiting S	Auna C. Jan, M. D. D14°	29d. Dete signed (Month, Day, Year) March 14, 2000	
State	31, Dele tiled (Month, Day, Year) 32, Registrar's Signeture	HOWARD, MARYLAND 21052	
Registrar	MAR 1 6 2003 Dener B. Sparks	*	

DHMH 16 Rev 6/95



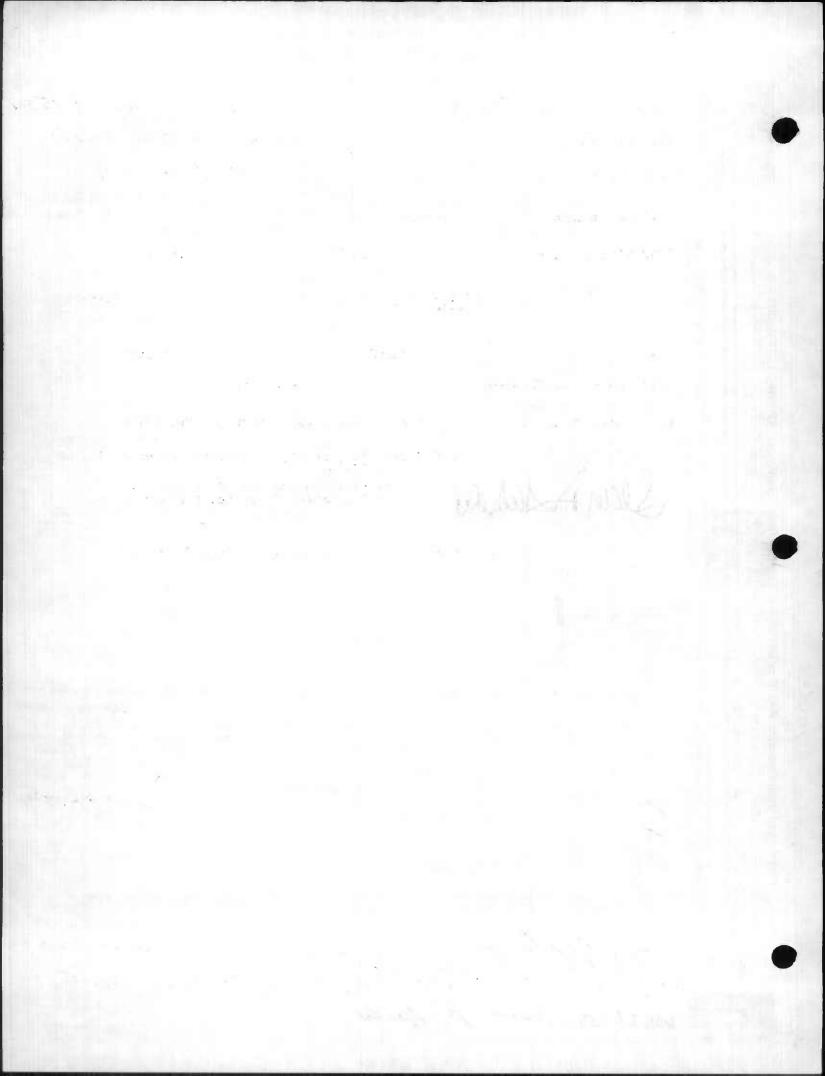
1. Decedent's Nama (First, Mana) STAN 4a Facility Nama (If not instited to the property of t	LEY aution, give		В									9 7	of Dard
HOSPICE OF 5. Social Security Number 215-12-8220 Usual Rasidence of Dacedar 10a. Stata 10b. Co			В.		T	UCKE		М		Day 2000	Yaar		of Death
Social Security Number 215-12-8220 Usual Rasidence of Dacedar 10a. Stata	DULLI			בית כיביאותי	רים		4b. City, Town FIMONII		on of Death	4c. County BALTI			
Usual Rasidence of Dacedar 10a. Stata 10b. Co	6. Sa:		7. Age (In yrs	last birthday) 79 Yrs.		r 1 Year Days	If Under 24	Hrs. 8.	Dete of Birth (Month, Day,	Year)			ta or Foraign
		•		75				J	UN. 18	, 1920		M	D
MD NI/Z	unty		10c. C	ity, Town or Lo	cation			00=			10	d. inside	City Limits
TID IN/F				BALTIM	ORE							15/	es 2 No
10e. Street and Number					10f. Zip				10	g. Citizen of V		ry?	
3011 FALLST				10 40 1	Man Dans		21208	2 (0	Van en Na	U.S.A.	a - America	n Indian	
11. Marital Status 1 Never Married 2 3 3 Widowed 4 Divo	Married	Armed Fo 1 W Yes If Yes, Giv Yaar or D	2 No				lispanic Origin an, Mexican, F Specify:	Puarto Rica	an, atc.)		k, White, e		
	dent's Edu			16a. Deced	lent's Usua	al Occup	ation	d wading	1	6b. Kind of Bu	usinass/Ind	ustry	
(Specify only h Elementery/Secondary (0-	12)	College (1	-4or 5+)	lifa. L	DO NOT u	se retired		WOINING					
17. Father's Name (First, Mic	2			PROPR	IETOR	R-IN	VESTOR	Name (F	inna Adiadata A	REAL E		Ξ	
SAMUEL	Ula, Last)			TUCKER			EST		rst, Mildule, IV	leiden Sumen		BAKE	0
19a. Informant's Name/Rele	Ionship (Tu	rpe, Print)				s (Street			outa Number	City or Town,			`
GERALDINE T			E							TIMORE			8
20a. Mathod of Disposition			20b.	Plece of Dispo-	sition (Na	ma of		T		Oc. Location -			
1 Burial 2 Cramal			State	AI ISRA				3/1	5/00	BALTI	MORE,	MD	
21. Signature Funeral Ser	vice Licegel	60 /	1	22	. Nama ar	nd Addra	ss of Facility	SOT T	EVINCO	N & BRO			
Marc).	trion	//	89	00 RF	ETSTI				KESVILI			208
disaasa or condition resulting in deeth) Sequentially list conditions, If any, laading to immadiata cause. Enter Undarlying Cause (Diseasa or injury that initiated events rasulting in death) Last	{	d	Dua to (etic or as a conseq of es or as a conseq or as a conseq	uence of):		ites		7			Jo	Ave
		d											
Pert II. Other significant con						causa giv	en in Part I.		23b. Did to	bacco uss co			
Corona	4 0	arter	y d	isen:	ce				1 🗆 Yı	8 28 No	3 Prob	ably 4	l 🗌 Unknow
	,							_	24a. Was er perform	autopsy ned?	COL	ilable pr	sy findings for to of cause
									1 □ Ya	s 2 No	10] Yas	2□ No
25. Wes casa rafarred to me axaminer?	dical						26. Place o	Death (C	heck only on	9)			
1 ☐ Yas 2 No	-	lospital:	npatient 2	ER/Outpatien			4LI NUIS	ing Homa	5 Raside	nce 6 BlOth	ar (Specify	160	5)92
- C 1100100111	nding astigation ald not be		th, Day Year)	28b. Time of Injury	М		yat k? Yas 2□No			w injury occur			
29e. Cartifier	termined	buildi	ng, etc. (Speci	noma, farm, stra ify) owledga, daath			ne, date end (City or Town	, Stata)			
(Check only 2 Med	cai Examir	ner: On tha ba	asis of examination ar stated.	ation and/or inv	rastigation	i, in my o	pinion, deeth	occurred e	ot the time, da	ite end plece,	and dua to	tha cau	ie(s)
29b. Signature and title of on	In So	my,	Pile	, m		0	e number	5	129	nd. Data signe	d (Month, I	Day, Yea	00
30. Nama and addrass of per W.A.R.	son who co	ABN	o of death (the	m 23a) (Type, I	Print)	Ch	ale	· S1	. Be	Parce eto,	nd	21.	204



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

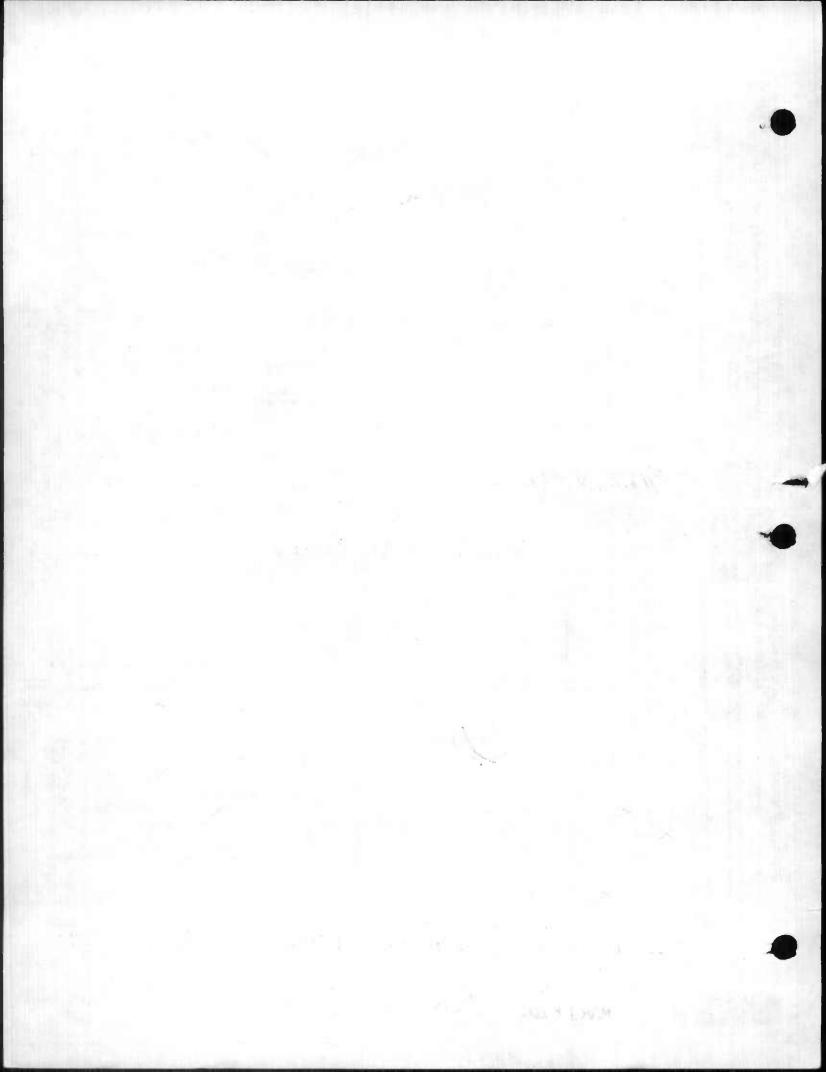
ysician Medical									Reg. No.		
Medical	1. Decedent's Name (First, Middle, I		mpson)		T		2. Date of D Month	H 12, 2	Year 2000	7°15A
caminer	John Oliz 4a Facility Name (II not institution, Academy Ford	1340/ B	n) reltimo	re-h	Vashing	an BLV	P, L	cation of Dea	the 4c. County		ensis
eral ctor	213-28-7393	. Sex 7. / 1⊠ M 2□ F	Age (In yrs. las 69	t birthday) Yrs.	II UNUBEL T	aar If Unda ays Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D) Feb. 2	th ay, Year) 4, 1931	9. Birthple Country Mary.	
tor	Usual Residence of Decedent 10a. State 10b. County Maryland Howard		10c. City, 1 Harw	Town or Loc	ation					10	d. Inside City Limits
al Director	10e. Street and Number				10f. Zip Co	de			10g. Citizen of \	What Countr	y?
a	4748 Flanders I	ane			2077	6			U.S.A.		
by Funeral Director	11. Marital Status 1 Nevar Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Forcas 1	nt Ever in U,S. s? No I 2-13-1 11-10-	948 1	Vas Decedent Yes, specify ☐ Yas 252	of Hispanic O Cuban, Mexico No Specify	rigin? (Spe en, Puarto :	ecify Yes or N Rican, atc.)		ce - America ck, White, at White	te.
Completed	15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	Education		16a. Decede (Give k life. D		ccupation one during mo atired)	st of worki	ng	16b. Kind of B		istry
Be	12 17. Father'a Neme (First, Middle, La William Harman			Gua	rd			(First, Middle	Secu , Maiden Suman		
2											
	G. Frances Thom			4748	Flande	rs Lane		rwood,	MD. 207	76	
	20a. Mathod of Disposition 1X Burial 2 Cremation 3 4 Donation 5 Other (Spe		te MD	Veter	sition (Name of altory or other an's C wnsvil	<i>place)</i> emetery	7 0	3-17-0	20c. Location - Crown		
	21. Signature of Funeral Service Lic	ensee d	M	22. A	Name and A mbrose	ddress of Faci Funera	T Ho		Lansdown Lansdown		. 21227
Wedical Examiner	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avents	a	Due to (or a	s a consequ	uance of):	ALO WIS	, easy	7700	+ Dis	043	
2	that initiated avents resulting in death) Last		Due to (or as	s a consequ		-					
	resulting in death) Last	d.	,		uance of):	e chien in Peri		23h Die	I tohacco usa co	antribute to	the cause of death
	Part It Other significant conditions	d	,		uance of):	e given In Parl	1 l.		l tobacco use co		the cause of death ably 4 ☐ Unknow
by Physician	resulting in death) Last	d	,		uance of):	e given In Parl	il.	1 = 24a. Wa		3 Prob	
pleted by Physician	resulting in death) Last	d	,		uance of):	e given In Pari	ıl.	1 24a. Wa	Yes 2 No	24b. We ava	ably 4 Unknown re autopsy tindings liable prior to splation of cause
To Be Completed by Physician	Part It Other significant conditions 25. Wes case referred to medical axapmar? 14 Yes 2 No 27. Manner of Death	Hospital: 1 □ Inpa 28a. Date of Ir (Month, L	but not resulti		iderlying caus	26. Pter	ca of Deetl	24a. Wa per 1 Check only me 5 Res	Yes 2□ No s an autopsy ormed? Yas 2⊅(No one)	24b. Wei ava com of d	re autopsy findings lieble prior to opletion of cause eath? Yes 2 \Bo
2 should be detached for upleted by Physician	Part It Other significant conditions 25. Wes case referred to medical axaomar? 12 Yes 2 No 27. Manner of Death 12 Natural 5 Pending	Hospital: 1 □ Inpa 28a. Date of In (Month, Little) 28e. Placa of In	but not resulti	ng in the un 2/Outpatient 8b. Time of Injury	ance of): iderlying caus 3 DOA 28c.	26. Pter Other: 4 Nork? Injury at Work? 1 Yes 2	ca of Deetl	24a. Wa per 1 Check only me 5 Res 28d. Describe	Yes 2□ No s an autopsy ormed? Yas 2□ No one)	24b. Wei ava com of d	re autopsy findings lebte prior to spletion of cause eath? Yes 2 No
pleted by Physician	Part It Other significant conditions 25. Wes case referred to medical examinar? 1 Yes 2 No 27. Manuar of Death 1 Natural 5 Pending investigal 3 Suicide 6 Could not determine 29a. Certifier 1 Certifying	Hospital: 1 □ Inpa 28a. Date of In (Month, Little) 28e. Placa of In	attient 2 EF	a/Outpatient 8b. Time of Injury e, farm, streedge, death	ance of): aderlying caus aderlying caus aderlying caus aderlying caus aderlying caus	26. Pter Other: 4 Nork? Injury at Work? 1 Yes 2 fica	ca of Deetl	24a. Wa per 1 Check only me 5 Res 28d. Describe City or To end due to the	Yes 2 No s an autopsy formed? Yas 2 No one) sidence 6 Ott how Injury occur (Street and Numi own, State) s cause(s) and m	24b. We ava com of d 1	re autopsy findings labte prior to spletion of cause eath? Yes 2 No Declaration Route Number,
Be Completed by Physician	Part It Other significant conditions 25. Wes case referred to medical axaprihar? 14 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 3 Suicide 6 Could not determine 29a. Certifier 1 Certifying (Check only 25 Medical Ex	Hospital: 1 Inpa 28a. Date of Ir (Month, E) 28e. Placa of I building. Physician: To the bes	attient 2 EF	a/Outpatient 8b. Time of Injury e, farm, streedge, death	ance of): aderlying caus aderlying caus aderlying caus aderlying caus aderlying caus aderlying caus	26. Pte Other: 4 N Injury at Work? 1 Yes 2 C fica me time, date a my opinion, de	oa of Deets	24a. Wa per 1 Check only me 5 Res 28d. Describe 28f. Location City or To end due to the ed at the time	S an autopsy ormed? Yas 20 No one) sidence 6 Oth how Injury occur (Street and Numicum, State) e cause(s) and me, date and place, 29d. Data signe	24b. We ava com of d 1	ably 4 Unknown re autopsy findings liable prior to replation of cause eath? Yes 2 No Declarsh) Route Number, ated. the cause(s)
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State of Maryland / Department of Health and Mental Hygiene

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				Cer	tificate	UIL	calli			Reg. No.		00	014
	1. Decedent's Nama (First, Midd	le, Last)						1	2. Data of De	ath	Ven		ime of Death
an al	GWEN ELIZABI	TH TOWNS	END						Month	14. 2	000 000		:00 AM
ai er	4a Facility Name (If not institutio					4b	. City, Tow		ation of Deat		ounty of De		.00 80
	6004 Hunt Ric	6004 Hunt Ridge Road, #2622						se E	states	es Baltimore Cou			untv
1	5. Social Security Number	6. Sax	7. Aga (In yrs. last birthday) If Under 1				If Undar 2		B. Data of Bir (Month, Da	irth 9.). Birthplace (Steta or Foreig Country)	
	328-42-1727	1□M 2∏F	51	Yrs.	MONITIS	Jeys	110015		Jan 1,	1949		lline	
ŀ	Usual Rasidance of Decedent		10- 0										
	10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City												
Maryland Baltimore County Elkridge Estates									J Yes ZXING				
ı	10e. Street and Number	10f. Zip Code					10g. Citizen of What Country?						
	6004 Hunt Ridge Road #2622 21210						USA						
I	11. Maritel Status 12. Was Decedant Ever in U,S. Armed Forcas? 13. Was Decede if Yas, specifi				Vas Deceden Yas, specify	dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Maxican, Puarto Rican, atc.)				14. Race - Amarican Indian, Bleck, Whita, atc.			
	1 Nevar Married 2 Married 1 Yes 2 No			☐ Yas 21		Specify:			Specify: White			0	
	3 Widowed 4 Divorced	Year or	Datas:		23								е
	15. Decedar (Specify only higha	it's Education st grade completed	1)	16a. Deced	ent's Usuel C kind of work	occupat done du	tion <i>uring</i> most o	of working	7		of Businas		
	Elementary/Secondary (0-12) Collega (1-4or 5+)				work done during most of working use retired)				Literary Book				
ŀ	47 Fathada Nama (First Affidd)	4			Pub1				(P**		ducti	on	
	17. Father's Name (First, Middla,								First, Middle				
1	Herbert Ward								Alice				
	19a, Informant's Name/Reletions	ship (Type, Print)		19b. Mailin	g Addrass (S	Street ar	nd Number	or Aural	Routa Numb	er, City or T	own, State	, Zip Code)	
	Craig A. Town	nsend (B	rother)	116	Midhur	st	Road,	Ba1					
	20a. Mathod of Disposition 1 □XBurlal 2 □ Crametion	3 □Removel from		Place of Dispos cematery, cram	sition (rvama natory or othe	or or place,)	1	Deta			or Town, St	
1	4 Donation 5 Other (S		Dr	aid Rid	lge Cer	nete	ery	13/	18/20	00 Pi	kesv	ille,	Mary1
	21, Signal of Ferenal Service	Libertido	-		Nema and				***	7			
	Martin D.	Lewson			litche!								0
1	23a. Part1. Entar tha disaesa, or	complications that	caused the deet	h. Do not anta	ar tha moda c	r K	such es a	Ball ardiec or	respiratory e	mest,	/land	Appro	ximate
1	shock, or haart failura. List	only ona cause on	aech line.									Onse	al Between t and Death
	Immediata Causa (Final disaasa or condition Metastatic Rectal Course									17	ouths		
	disaasa or condition rasulting in death)	a	Die to (or as a consequ	,		·			_		1 - 101	ONLINE
			Dua to to	n as a conseq	derice orj.							1	
	Sequentially list conditions	b	Due to fe	er as a consequ	uence of):							-	
	Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disaase or Injury that initiated events												
1	Cause (Disaase or Injury that initiated events	C	Dua to (o	r as a consequ	uance of):							1	
	rasulting In death) Last												
		d											
	Pert II. Other algorificant condition	ons contributing to	death but not res	ulting in the un	dariving caus	se diver	n in Part I		23b Did	tobacco us	e contribu	te to the c	euse of death
	Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I.					23b. Did tobacco use contributa to the cause of death 1 Yes 2 No 3 Probably 4 Unknow							
1 Yas 2DNo 3 Probably									4□	Yes abe	No 3	Prohehly	
									10	Yas 20x	Ño 3□	Probably	
									24a. Was	an autopsy	1	o. Were aut	opsy findings
									24a. Was		1	o. Were aut	opsy findings prior to on of cause
									24a. Was	an autopsy ormed?	248	o. Were aut available completic of death?	opsy findings prior to on of cause
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	25. Was case referred to medica axaminar? 1 □ Yas 22 No	Hospital: 1		ER/Outpatient		Other	r: 4 Nurs	sing Hom	24a. Was perfo	an autopsy primed? Yas 2	24l	b. Were autavaileble completic of death?	opsy findings prior to on of cause
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Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 8, 2000 **Physician** Mary Laurentine Voelker 11:50PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Villa Assumpta 6401 N. Charles St Baltimore Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Months Days 1 M 2 F Yrs. 215-68-1896 January 15, 1913 Maryland Usual Residence of Deceden 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6401 North Charles Street 21212 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (X) Yo If Yes, Give Year or Dates: 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decadent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Teacher Parochial School 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be George Voelker Theresa Mueller 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) SSND Bernice Feilinger 6401 North Charles Street Baltimore, Maryland 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Durial 2 Cremetion 3 Removel from State Villa Maria Cemetery 3/11/00 Glen Arm, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. makin 6500 York Road Baltimore, Maryland 21212 Lennis 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Finef disease or condition resulting in death) Emphysema 1 year Due to (or as a consequence of): Physician/Medicai Examiner Coronary Artery Obstruction Year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or es a consequence of) Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes an autopsy performed? 1□ Yes XX No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home XX Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 1 XX etural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide **Cortifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the ceuse(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and magnify stated. 29a. Certifier (Check only one)

or Attending Physicien: The isw requires that the death certificate be associted Box 68760. P.O. Division of Vitai Records, To the Hospital or Attendir within 24 hours after death. To the Funerel Director: A

Funeral

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29b. Signature and title of certifier

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Baitimore, Maryland

Registrar

DHMH 16 Flev 6/95

31. Date filed (Month, Day, Year) 6 2000 MAR

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 32. Registrar's

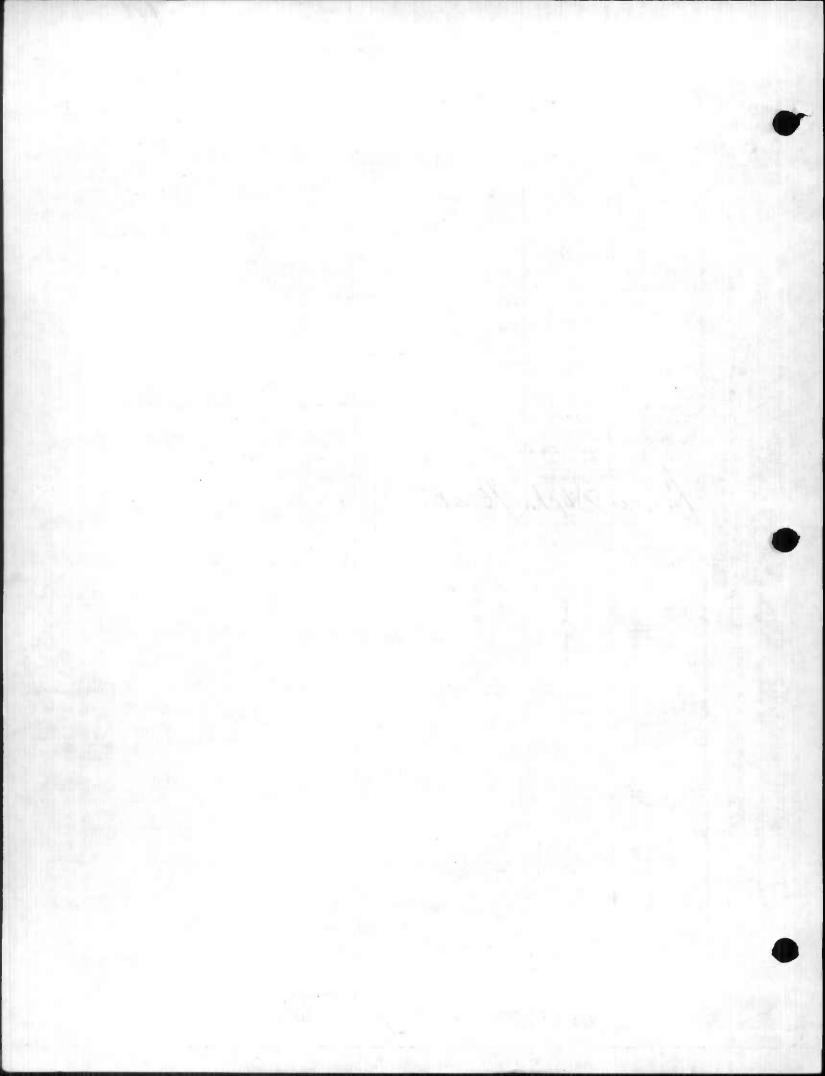
7505 Osler Drive Towson MD 21204

29c. License number

D-01373

29d. Date signed (Month, Day, Year)

3/9/00



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND#17 PER A.B. G786 8-4-2000 JAB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** WILSON ALEX ANDRIA 310 /Medical 4b. City, Town, or Location of Death 4a Facility Nema (If not institution, give street and number) 4c. County of Death **Examiner** BALTIMORE MARYLAND 5. Sociel Security Number Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Director none Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Frederick Frederick 1 ☐ Yes 2 ☐ No Directo 25a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 23a 1816 River Mist Court 21701 USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☒ No
If Yes, Give Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ black 3 Widowed 4 Divorced Yeer or Detes Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondery (0-12) College (1-4or 5+) none none none 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) nt of Health and Mental H t: If them 27 is marked oth r or other traumetic even Be Pages 1 and 2 should be nent of Health and Mental Stacey Wilson unknown ROGER WILSON 19a. Informant's Neme/Raletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD University of MD Medical Center 22 S. Greene Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 5 NOther (Specify) in state 21. Signature of Funeral Service Licensee Rohald S. Wade, Director 22 Name and Address of Facility Board 655 W. Baltimore Street Baltimore, MD 21201 . Enter the disaase, or complications that caused tha death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, or heert failura. List only one cause on each line. Approximate Interval Between Onset end Death **Physician** /Medical Immediate Cause (Final PULMONARY HEYORRHAGE disease or condition resulting in deeth) **Examiner** TENT DUCTUS Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury that initieted events rasulting in death) Last Box 68760, Physician/Medical for use as Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part t. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probebly 4 ☐ Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 X Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: 25. Was case refarred to medical axaminer? Be 26. Place of Death (Check only one) Hospitel: 1 Impatient 1 Yes 20 No Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Netural within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier (Check only one) To the

State Registrar

29b. Signeture and title of certifian

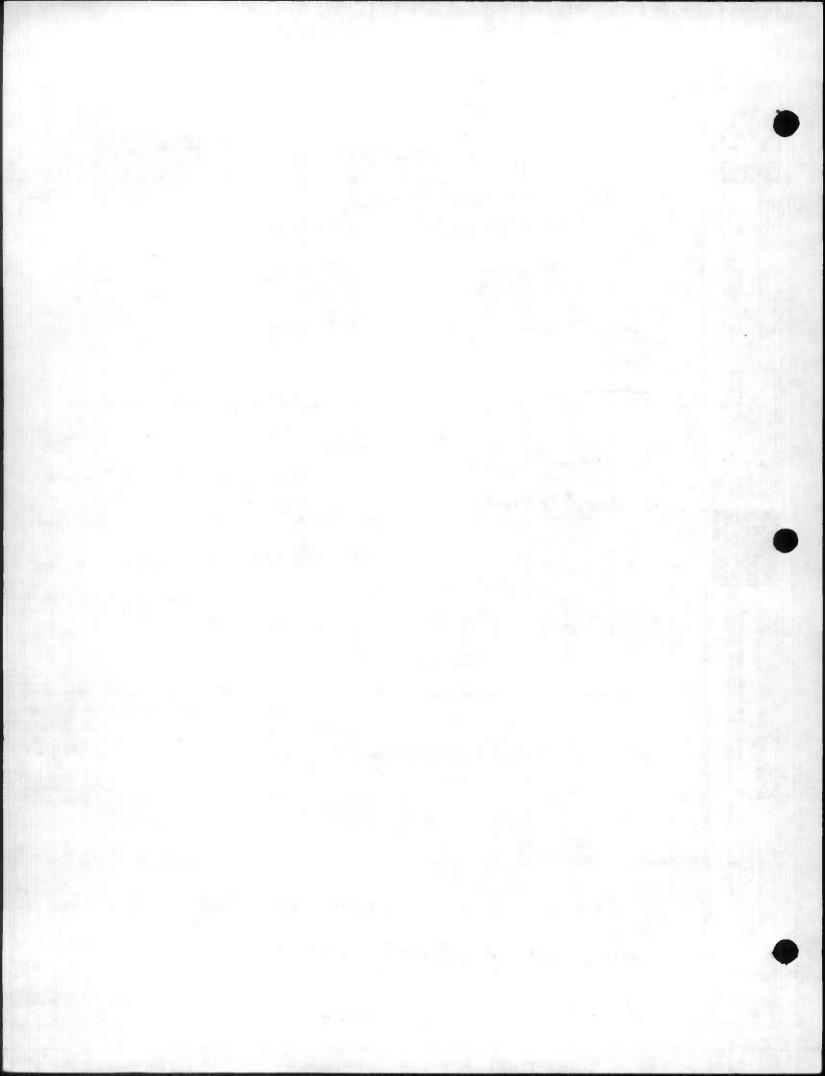
32. Registrar's Signature

30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

MARYLAND

29d. Date signed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month Physician Mary Magalene Grant Wynn 13, 2000 8:00pm Mar. /Medical 4a Facility Nema (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 101 Bragg Blvd. Odenton Anne Arundel If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) VA 8. Data of Birth (Month, Day, Year) **Funeral** Months Davs Hours 1 M 2 F 230-52-6721 67 Director 02-28-33 Usuai Rasidance of Decedant 10b. County 10c. City, Town or Location 10d. Inside City Limits na 23a or 28a-f ahow must be notified at Anne Arundel Odenton 1 Yes ZONo Director MD 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? USA 21113 101 Bragg Blvd. Funerai 11. Meritel Stetus Wes Decedent Evar in U.S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Heelth and Mentel Hygiene. Important: if frem 27 ie marked other than "natural", or hen any injury or other traumatic event, the Medical Exercise page. Black, Whita, etc. 1 ☐ Yes 2 🔀 No If Yas, Giva 1 Nevar Merried 2 Married 1 Yes 2X No Specify: Specify: Black þ 3 Widowed 4 Divorced Yeer or Detes: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elamentary/Secondery (0-12) Collega (1-4or 5+) Middle School Teacher Suffolk Public Schob 12 5+ 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louisa Mae Jenkins Troy Lee Grant 19a. Informant's Neme/Raletionship (Type, Print) 19b. Maiting Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 101 Bragg Blvd. Odenton, MD 21113 Gloria W. Lilly-daughter 20b. Place of Disposition (Name of cematery, crematory or other p 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata Green Lawn Cemetery 3-20-2000 1 X Buriel 2 ☐ Cramation 3 ☐ Removel from Stata Chesapeake, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensee 22. Nama and Address of Facility Baltimore, Maryland 21202 lady Warne WM.C.March FH 1101 E. North Avenue 23a. Part 1. Enter the disaasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heef failure. List only one ceuse on each line. Physician Melastatic Endo melria Carcinome /Medical tmmediata Causa (Final disaase or condition rasulting in death) Examiner Examiner Sequentially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably & Unknown P Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical exeminar? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 \(\text{\text{Nursing Homa}} \) 1 Nursing Homa | 5 \(\text{Residence} \) Residence | 6 \(\text{\text{Other}} \) Other (Specify) Medical Certification: To 27. Menner of Death 1 DNetural 2 Accident 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 5 Pending 1 Tyes 2 No invastigation 6 Could not be determined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of tnjury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homlcida

To the Hospital or Attend within 24 hours after death To the Funeral Directors.

The law requires that the death certificate be executed

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P.O. Box 68760.

Division of Vital Records,

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altimore, Maryland

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Ramen Sabapathy Suire 80 32. Registrar's Signature

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Descripting Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

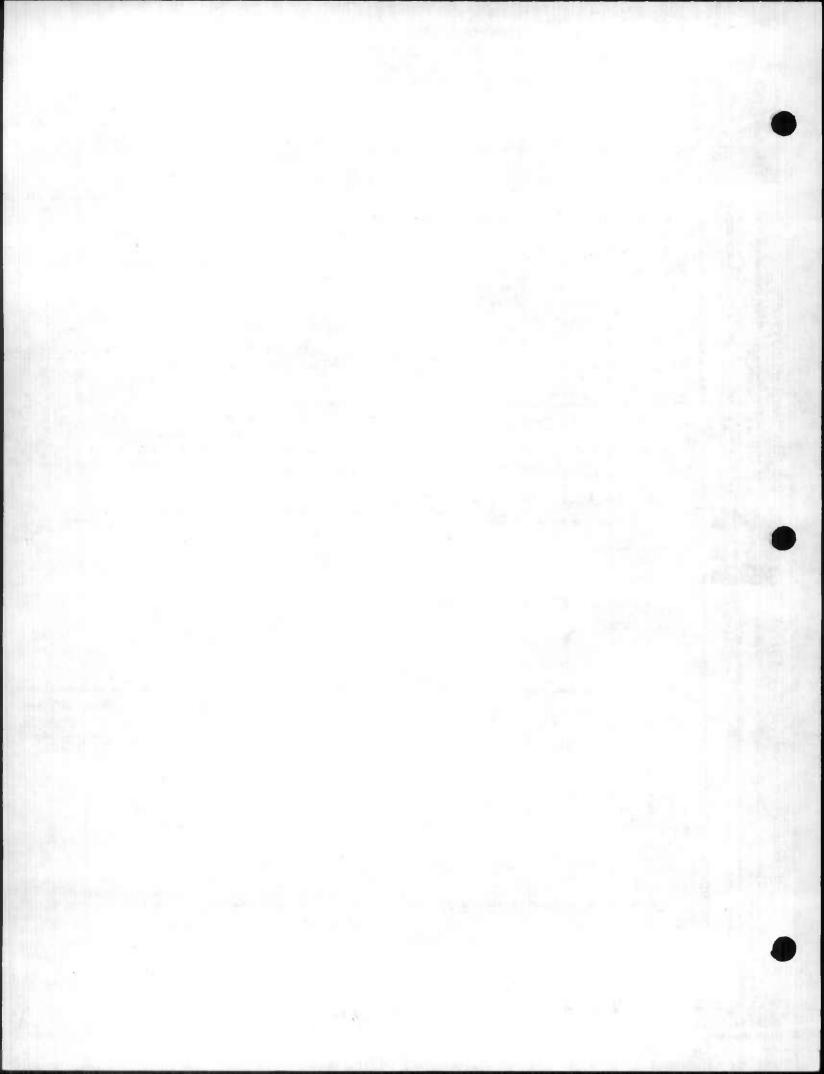
29c. License number

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821 N. Eutaw St Baltime MOZHO

16th March 2000.



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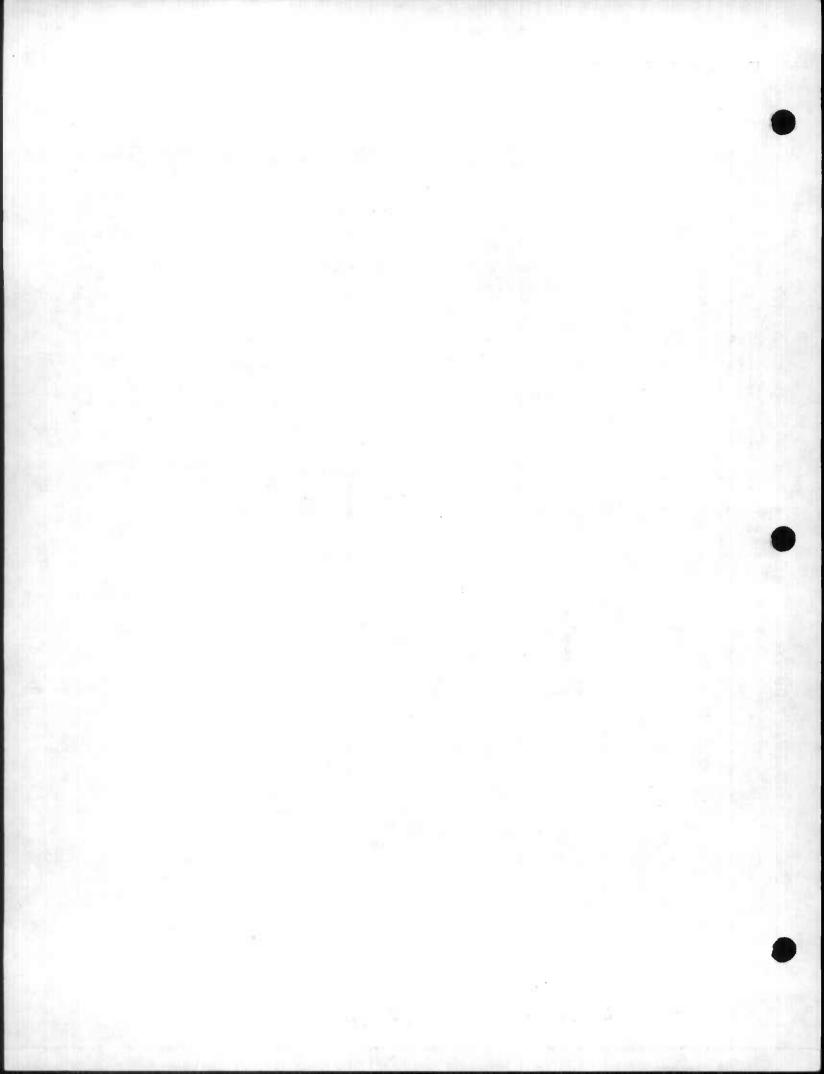
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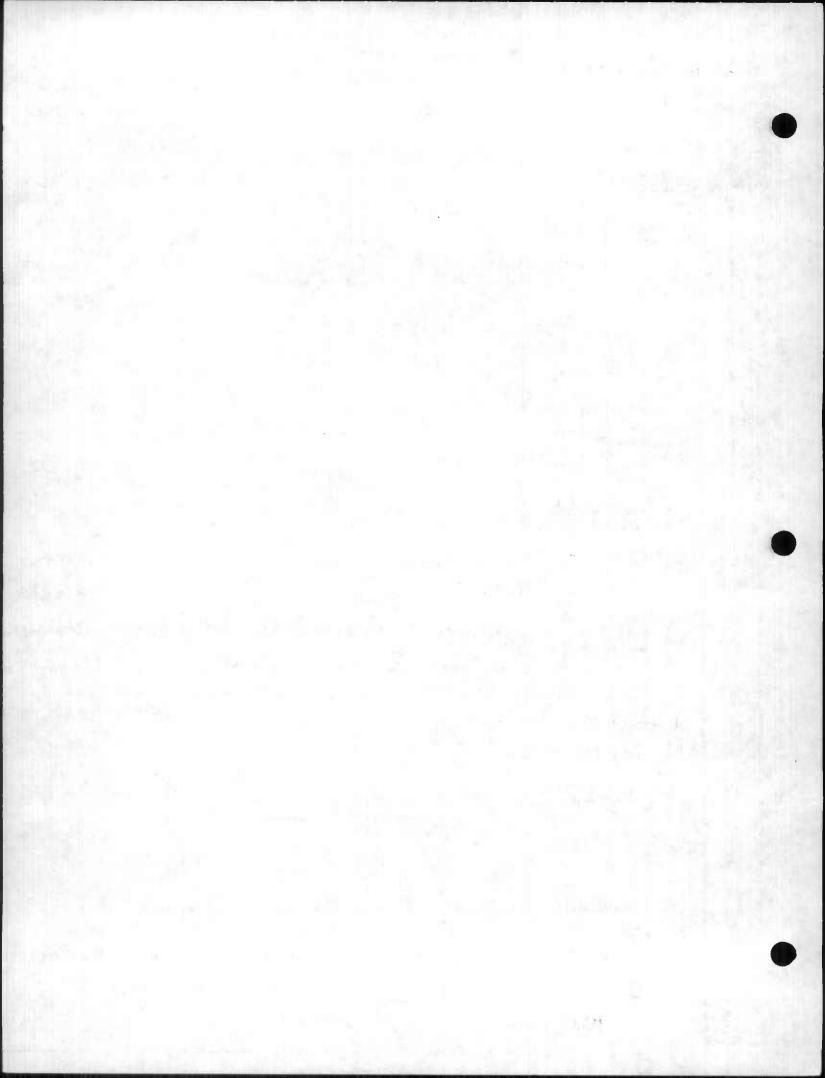
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State of Maryland / Department of Health and Mental Hygiene

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	/Medic		Phillip Russell Williams		2000
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1	Funeral		5. Sociel Security Number 6. Sex 7. Age (In yrs. last blimbdey) If Under 1 Yeer If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)	Birthplace (State or Foreign
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	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Med	29b. Signators and title of certifier. 29c. License number		(Month, Day, Year)
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N. A	1/10		30. Name and address of person who completed ceuse of death (Item 23e) (Type, Print)	rearc	17,2000
Al.	2		3333 N. Calvert St., Ste 575, Ba	Itimore, W	1D अग्राध .
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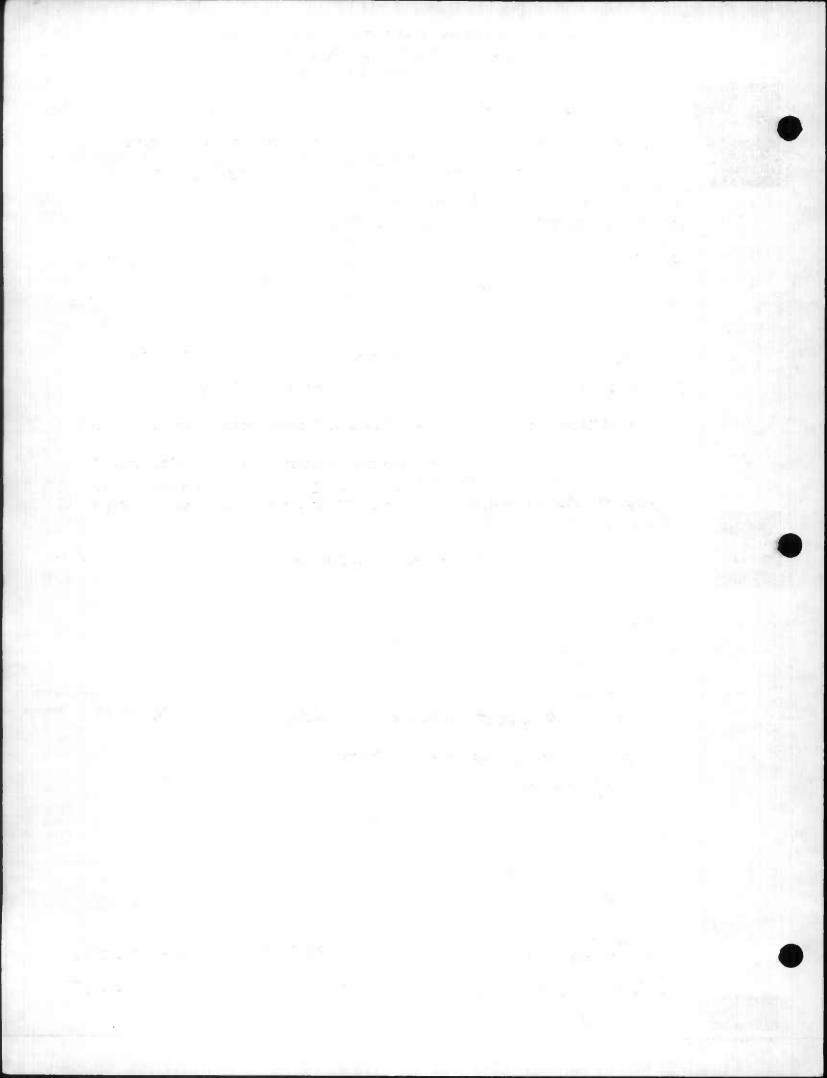


State of Maryland / Department of Health and Mental Hygiene

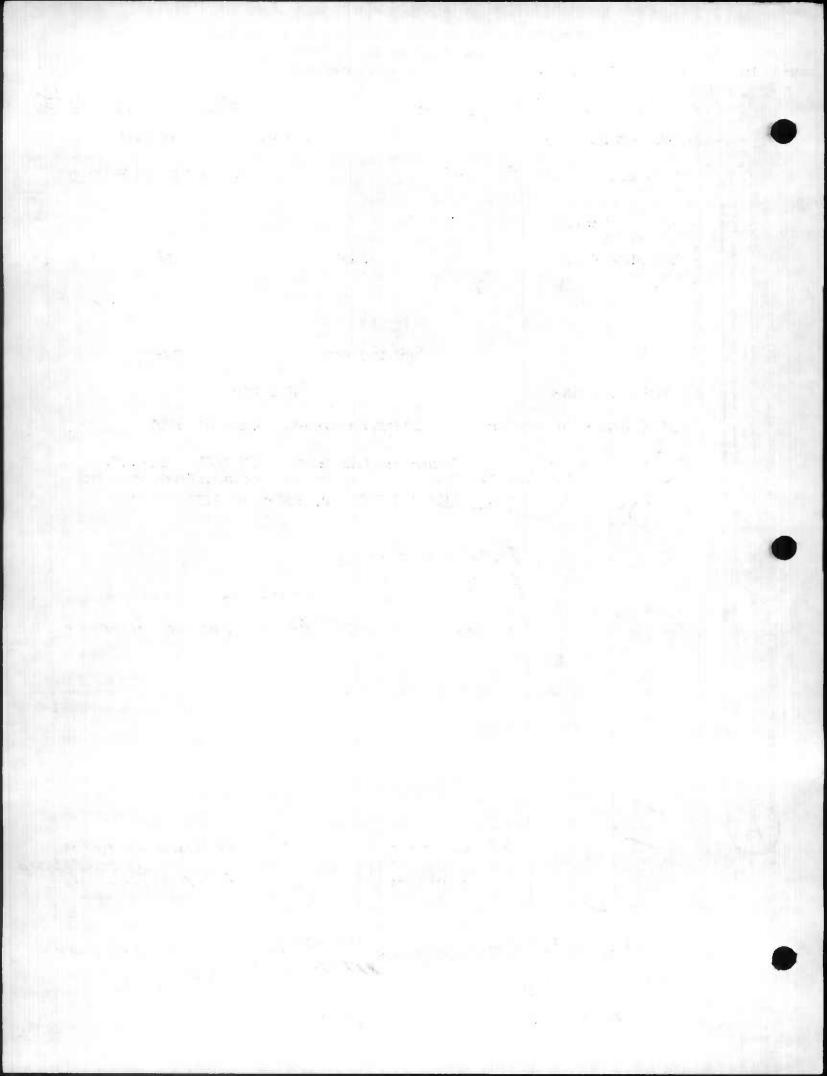
Certificate of Death 1. Decedent's Nama (First Middle Last) 2. Date of Death Month **Physician** Judith H. Wall 2000 March 6:20am /Medicai 4a. Facility Nama (If not institution, giva street and number) 4h City Town or Location of Death 4c. County of Death Examiner 7305 Kitchens Drive Marriottsville Howard If Under 1 Yeer | If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) 5. Social Sacurity Number 7. Age (In yrs. last birthday) Birthpleca (Stata or Foreign Country) **Funeral** 1□M 2MF Yrs Director 57 Feb 14, 1943 219-40-3473 MD Usual Rasidanca of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hypere.
Department of Health and Mental Hypere.
Department of Health 27 is marked other than "natural", or Herre 23a or 28a-1 shown any injury or other traumatic event, the Medical Examinar must be notified at 1 Tyes 2 TiNo Director MD Howard Marriottsville 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 7305 Kitchens Drive 21104 United States Funerai 12. Was Dacedent Ever In U,S. Armed Forcas? 1 ☐ Yas 2 ᠫ No If Yas, Giva Yeer or Dates: Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 14. Race - Amarican Indian Black, Whita, atc. 1 □ Navar Married 2 □ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: by 3X Widowed 4 □ Divorced Specify: White Completed Decedant's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Spacify only highast grade completed) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 12 Research Secretary 17. Fathar's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Be William E. Koch Helen D. Clardy 2 19a. Informant's Neme/Ralationship (Typa, Print) 19b. Meiling Address (Street end Number or Rural Routa Numbar, City or Town, State, Zip Code) Kelley Wall/Daughter 7303 Kitchens Drive Marriottsville, MD 21104 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) New Cathedral Cemetery 3-17-2000 Baltimore, MD 21. Signeture of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Harry H. Witzke's Family Funeral Home, Inc. m01044 Glo mo - Why 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disaesa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intarval Between **Physician** /Medical Immadiate Ceusa (Final refounded intention 1 hm disaasa or condition rasulting in daath) Examiner Examiner physician and s the buriel-transit Sequantially list conditions, if any, laeding to immadiata cause. Enter Underlying Causa (Disaasa or injury thet initiated evants rasulting in death) Lest Dua to (or as a consaquanca of): P.O. Box 68760 Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 10 consulie dependent dealet mellete 3 Probably 4 Unknown Records, by 24b. Wara autopsy findings availabla prior to complation of cause of death? 24e. Wes an autopsy performed? Completed perpheral paparlos diserse 25. Was casa referred to medical axaminar?

1 Yas 2 No 1 ☐ Yas 2X No 1 ☐ Yas 2 ☐ No Division of Vital Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4□ Nursing Homa 5 1 Rasidenca 6 □ Other (Specify) 2 After this funeral 28d. Dascribe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? Certification: To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Netural 5 Panding 1 Yes 2 No investigation 2 Accident 8 Could not ba 3 Sulcida Location (Straet end Number or Rural Routa Number, City or Town, Steta) 28a. Place of Injury - At home, farm, streat, factory, offica building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end manner as steted.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner steted. 29a. Certifier Medical 29b. Signatura and titla of cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 937777 March 15, 2000 30. Nema and addrass of person who completed cause of deeth (Itam 23e) (Type, Print) 2 KNOW NORTH DY COLUMNSIA MD 2/0 KJ 31. Data filed (Month, Day, Yaar) 32. Registrar's Sanature State 2000 Registrar



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Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decadent's Nema (First, Middle, Last) 2. Dete of Deeth Month ELSIE ZEUCH IRENE 11:08 P.M. 14, 2000 March 4e. Facility Neme (If not institution, giva street end numbar) 4b. City, Town, or Location of Daath 4c. County of Deeth Augsberg Luthern Home Baltimore Baltimore 5. Sociei Security Number If Under 1 Yaar If Undar 24 Hrs. Months Deys Hours Min. 7. Aga (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Yeer, Birthplace (State or Foreign Country) Deys Hours 1 ☐ M 2 🖾 F 215-34-8462 Yrs. 91 July 22, 1908 Maryland Usuei Residence of Decedent 10e Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21212 630 Overbrook Road U.S.A. 12. Was Decedenf Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Yeer or Detes: 1 ☐ Never Marriad 2 ☐ Married 1 ☐ Yes 2 ☑ No 3 NWidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest greda completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Homemaker 12 years Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Paul Stiegmann Anna Rebecca Dove 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, Maryland 21212 Shirley Lewis (daughter) 630 Overbrook Road 20e. Method of Disposition 20b. Piece of Disposition (Neme of cemetery, crametory or other plece) 20c. Location - City or Town, Stete 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Othar (Specify) 3-18-2000 Woodlawn, Maryland Woodlawn Cemetery 21. Signetura of Funerai Service Licensee 22. Neme and Address of Fecility Mitchell-Wiedefeld Funeral Home, Inc. 23e. Part1. Enter the disaate, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heert feilure. List only one ceuse on each line. 6500 York Road Baltimore, Maryland 21212 Immediete Ceuse (Finel diseese or condition resulting in death) Parkinson's Due to (or as e consequence of): Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Disease or Injury that initiated events resulting In death) Lasf Due to (or es e consequence of) Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 215 No 3 Probably 4 Unknown 24b. Were autopsy findings eveilable prior to compiation of cause of deeth? 24e. Wes en eutopsy 1 ☐ Yes 2 ZNo 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicel examiner? 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4₺Nursing Home 5☐ Residence 8☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturei 5 Pending 1 Yes 2 No investigetion 2 Accident 3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier To the best of my knowledge, deeth occurred et the time, date end piece, end due to the ceuse(s) end menner as steted. | Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, dete end place, and due to the ceuse(s) and menner stated.

I or Attending Physician: The law requires that the death certificate be executed efter death.

Director: After this certificate has been signed by the ettending physician and Division of Vital Records, P.O. Box 68760, To the Hospital within 24 hours e To the Funeral C

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Items 23a

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Certification:

Medical

72 hours efter

Baltimore, Maryland 21215-0020

Examiner must be notified at

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State Registrar

31. Dete filed (Month, Dey, Year) MAR 1 6 2000

29b. Signetura and title of certifier

32. Registra Signature



30. Name end eddress of person was acropieted cause of deeth (item 23a) (Type, Print) TEZO Park Heights Jef Zobell MD

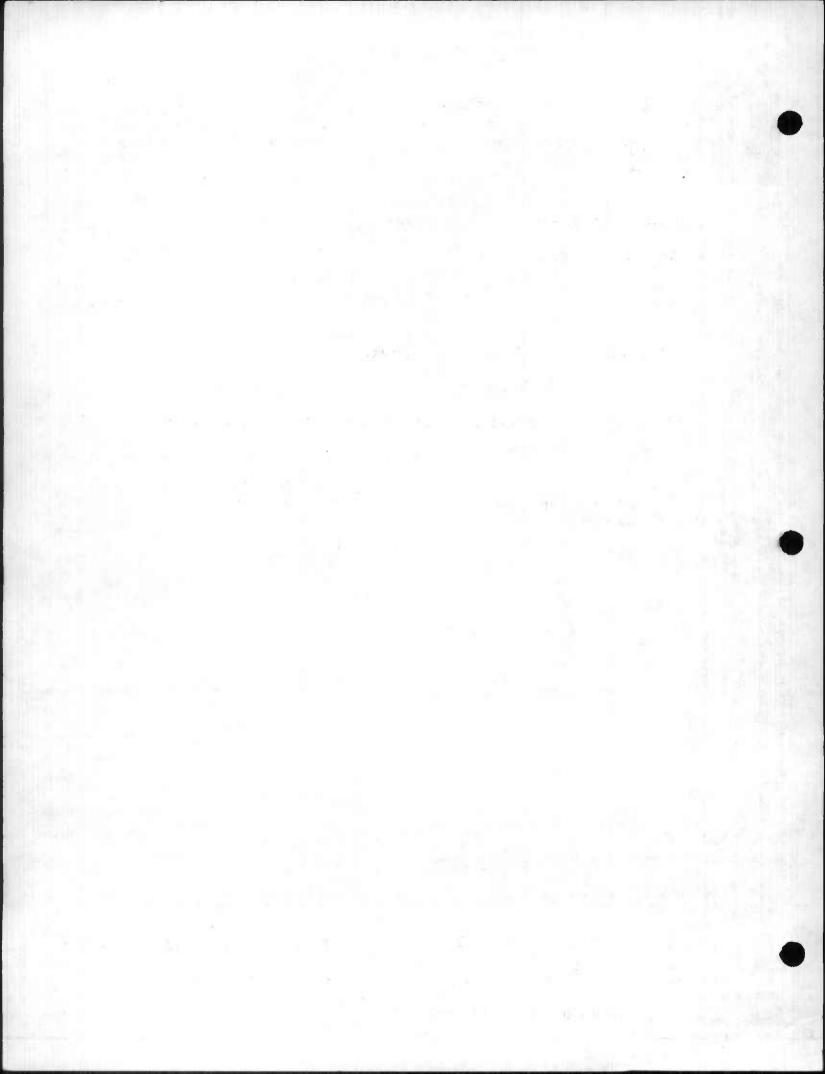
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29d. Date signed (Month, Dey, Year) March 15, 2000

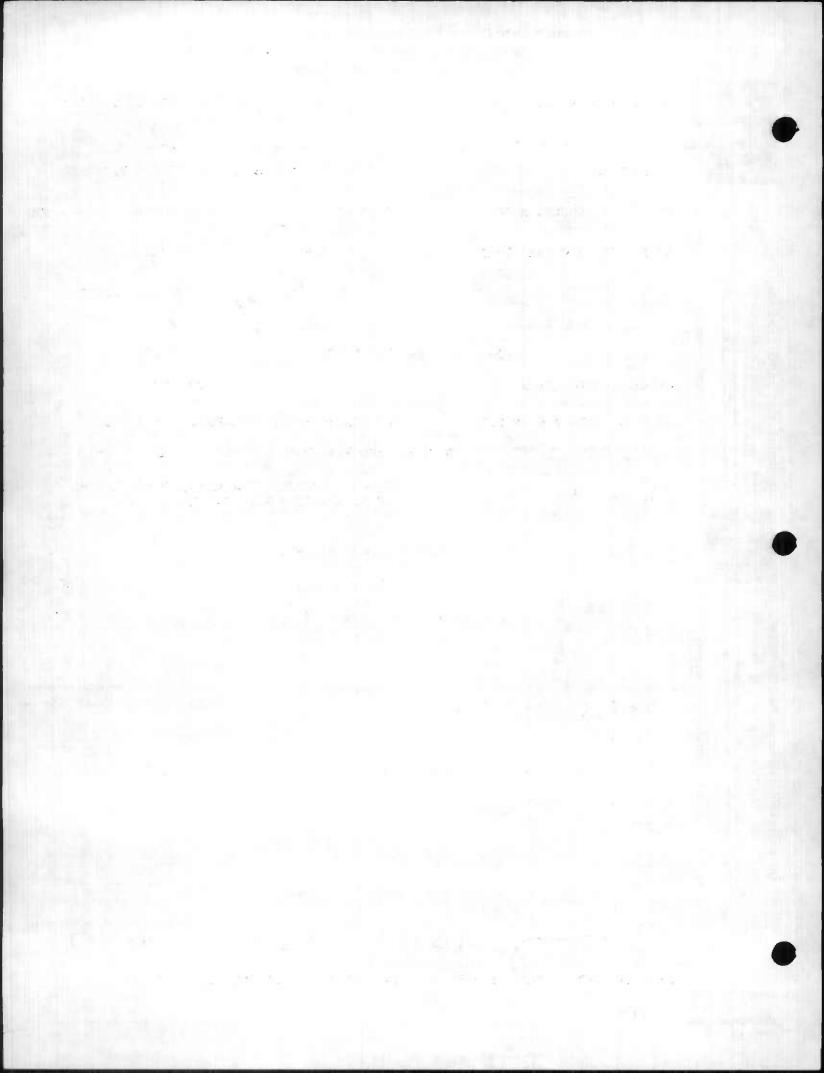
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DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 08883

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/Medica Examine		4a Facility Name (If not institution, gi	ve street and number,)				4b. City, To	wn, or Lo	ocation of Death	4c. Cou	nty of Death)	
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72 hours effer death with the Maryland naturel', or iteme 23s or 28s-1 show dical Examiner must be notified at	Funeral	11. Maritel Status	12. Was Decedent		13. V	Vas Deced	ant ot H	lispanic Or	igin? (Sp	ecify Yas or No		Raca - Amar		
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To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:													
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		HEATHER MORPHY,	1.1				TE	#2 C	нест	FRTOLIM	MD 21	620		
04-4		31. Deta tiled (Month, Day, Year)		rars Signatur		loon		, 2, 0	TOTI	TICT OWIN,	rw Z1	020		
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State of Maryland / Department of Health and Mental Hygiene 08884 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2000 Month 1140 a.m. March 3, Newman BLUMENTHAL

Physician /Medical Examiner

Wilma

Funeral

Director

than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at filed within 72 hours after of Hygiens. other than "natural", or Item permit. Pages 1 and 2 should be illed with Department of Health and Mental Hygien (important: if them 27 is marked other than any injury or other traumatic event, that ODEs.

Baltimore, Maryland 21215-0020

Physician /Medical Examine

physician and the burlet-transit The lew requires that the death certificate be executed Box 68760, 987 Division of Vital Records, P.O. signed by ti peen s To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director,

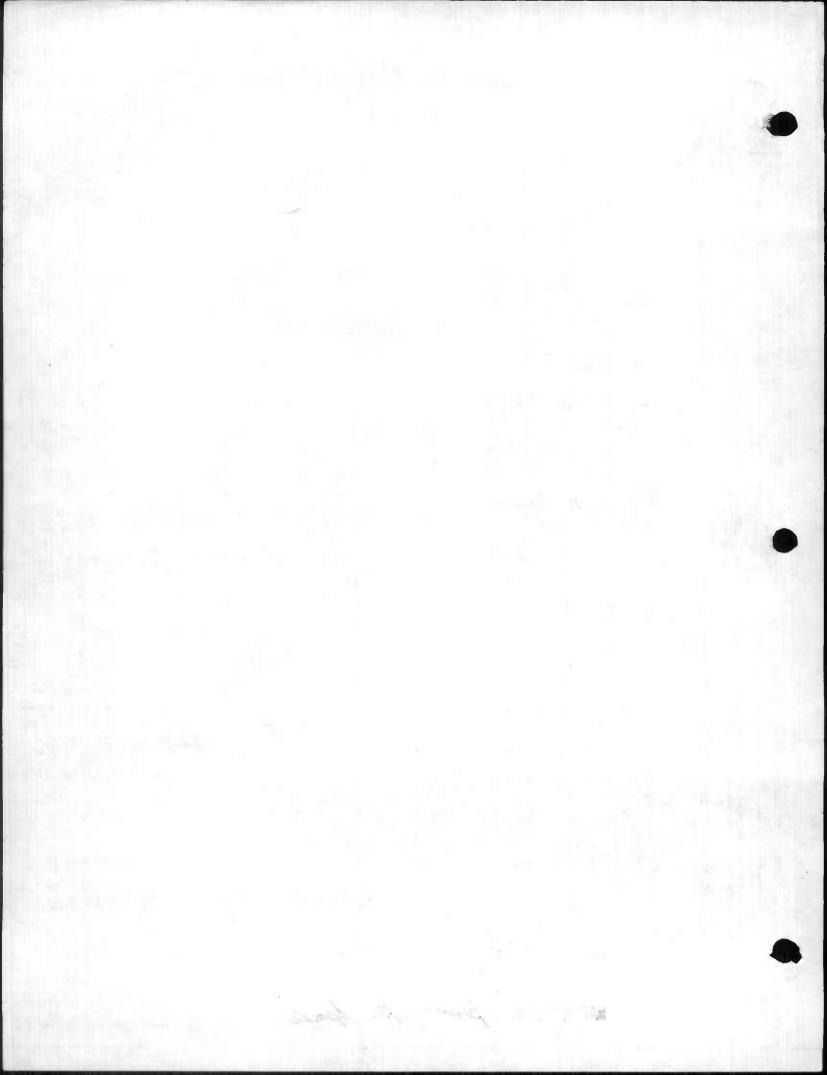
10 State Registrar

4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert. If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV 11, 1915 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days 1□M 2♥F Hours 579 05 1164 84 South Carolina Usual Residence of Decedent 10b. County 10s. State 10c. City, Town or Location 10d. Inside City Limits Prince Frederick 1 ☐ Yes 2 No Maryland Calvert Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20678 USA 85 Hospital Road Funeral 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: þ 312 Widowed 4 ☐ Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Cecil Eric Newman Lillie Reece 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11903 Crown Drive, Dunkirk, MD 20754 Lenora Davis /daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removat from State 4 ☐ Donation 5 ☐ Other (Specify) 3-6-00 Cedar Hill Cemetery Suitland, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, Owings, MD 23a. Part1. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only no cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) of Unknown Primar Accinomy Due to (or as a consequence of): Examiner Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown I Dabetes à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? erchanger lan Accident 21 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical axaminer? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 | Inpatient 2 | ER/Outpetient 3 | DOA 27, Manner of Death 28a. Date of tnjury (Month, Day Year) 26b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) edical 29a. Certifier niner: On the basis of exam (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Prince Frederick, MD <u>Jonathan Lowenthal</u>, M.D., 20678 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 16 Rev 6/95

MAR 0 7 2000



Registrar

29b. Signature and title of certifier

Johns Hopkins 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause d

MAR 1 6 2000

Itospital

32. Registar's Signature

Recent

DHMH 16 Rev 6/95

death (Item 23a) (Type, Print)

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29c. License number

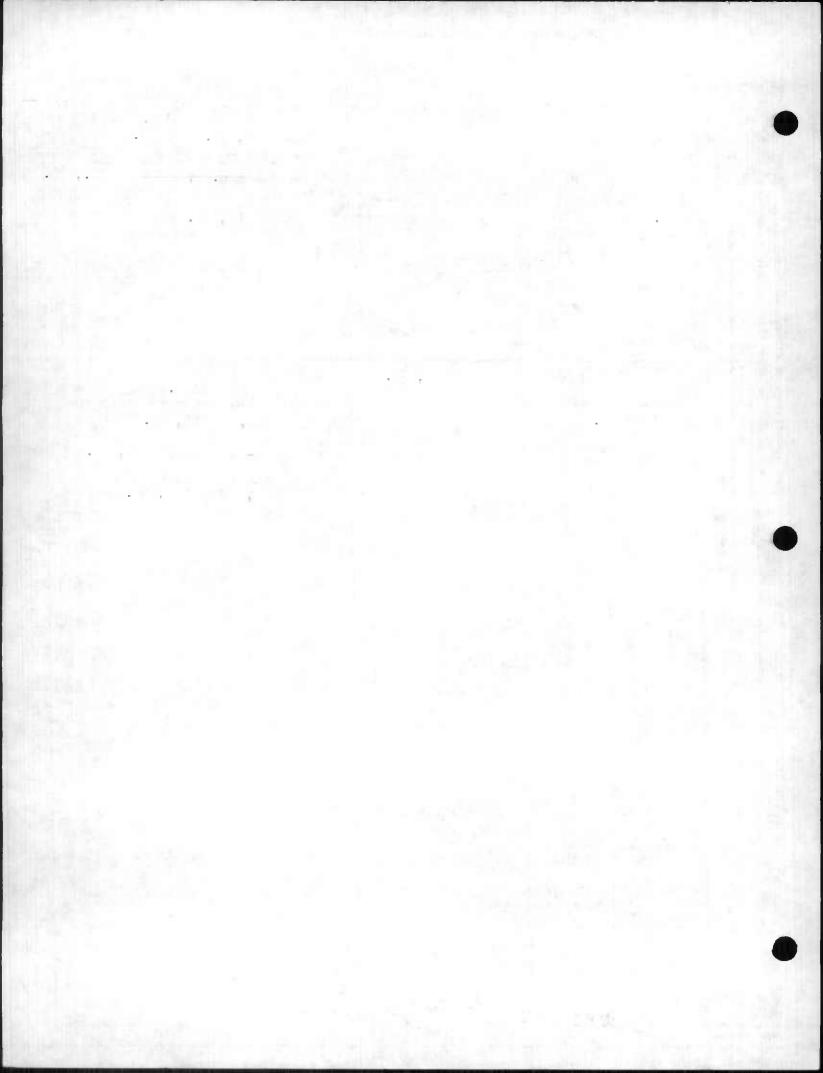
D0051144

Susan W Aucott md

29d. Date signed (Month, Day, Year)

Wolfe Street Raltimore MD 21287

MARCH BIGHTH, 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MARCH 2000 10:30AM EDITH DORIS BELCHER /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LOTHIAN ANNE ARUNDEL 182 MAIN STREET If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 F 70 Yrs. 228-28-2641 Director DEC. 14, 1929 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 Yes 20No MARYLAND ANNE ARUNDEL LOTHIAN Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or hams 23s or U. S. A. 20711 Funeral 182 MAIN STREET 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or Nott Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. 11. Marital Status Bleck, White, atc. filed within 72 hours after. Hygiene. ther then "natural", or its 1 Yes 2 XNo
If Yes, Give
Year or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 Specify: WHITE 1 Yes 2 No Specify: à 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Papes 1 and 2 about be filed w
Department of Health and Mental Hygien
Important: if Nem 27 is marked other the
any injury or other trauments. HOSPITAL 2 NURSE'S AID 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be ROBERT INGLE VERNA EDWARDS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) 1312 BUCK'S LANE LUSBY, MARYLAND 20657 NORMA J. CAREY/DAUGHTER 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20a. Method of Disposition MARCH 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 9,2000 CHELTENHAM, MARYLAND MD VETERANS CEMETERY 21. Signature of Funeral Service Lice 22. Name and Address of Facility LEE FUNERAL HOME CALVERT, P.A. 8125 SOUTHERN MD BLVD. OWINGS, MARYLAND 20736 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, or hourt tailure. List only one cause of each line. Approximeta Intervel Between Onset end Death **Physician** /Medical Immediate Cause (Final runma disease or condition resulting in death) Examiner Examiner attending physician and for use as the buriel-transit that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es a consequence of) Box 68760. Physician/Medical that initieted events resulting in death) Last Due to (or as e consequence of): Part It. Other significant conditions contributing to death but not resulting to the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ò The law requires 24b. Were eutopsy tindings evailable prior to completion of cause of death? 24a. Wes an autopsy performed? Completed pege 2 s has of Vital 25. Was case referred to medical examiner? Be 28. Place of Deeth (Check only one) Hospitel: 1□ Yes 2NNo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manper of Death
1 Naturat
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? After Division Attending 5 Pending investigation To the Hospital or Attending within 24 hours etter death.

To the Funeral Director: Afte completely filled in by the fun. 1 Yes 2 No 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify) 4 THomicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. edical 29a. Certifier (Check only one) 29b. Signeture and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) lunistonson 00027189 MARCH 6, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2417 SOLOMONS ISLAND RD., N. HUNTINGTOWN, MARYLAND ZAHIR YOUSAF, M.D.

DHMH 16 Rev 6/95

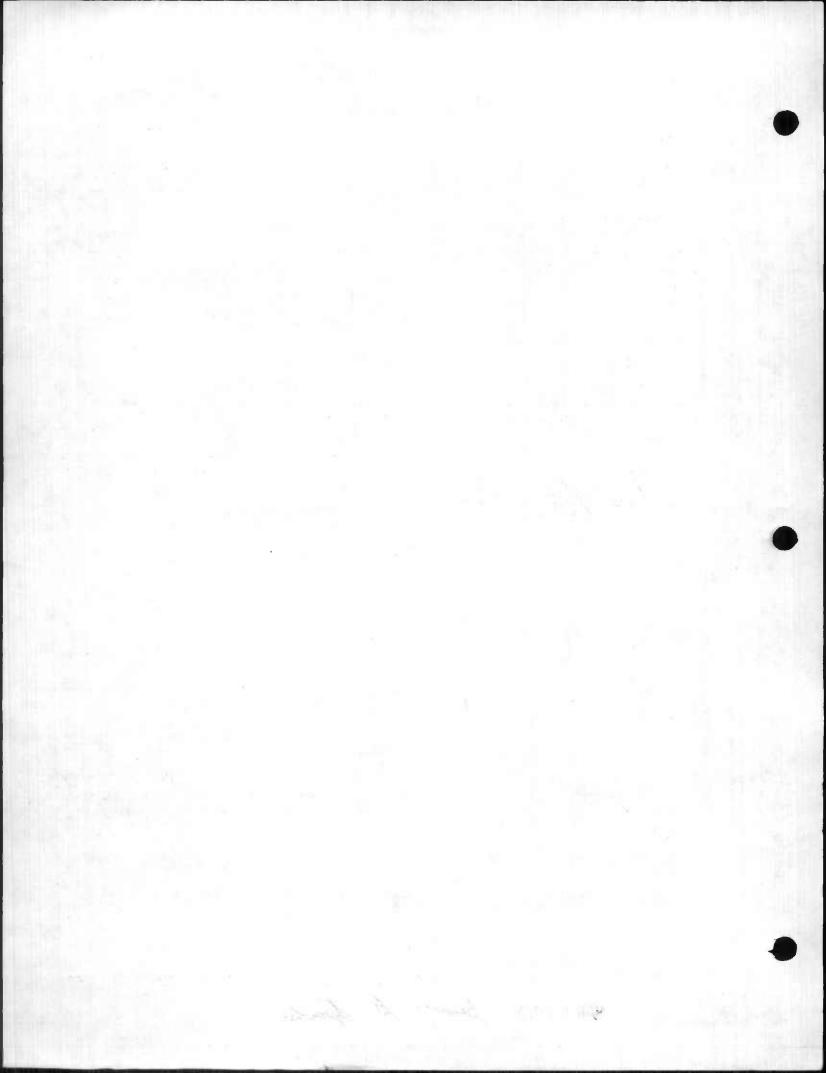
State

Registrar

31. Date filed (Month, Day, Year)

32. Registrads Signeture

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Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

2/35/10

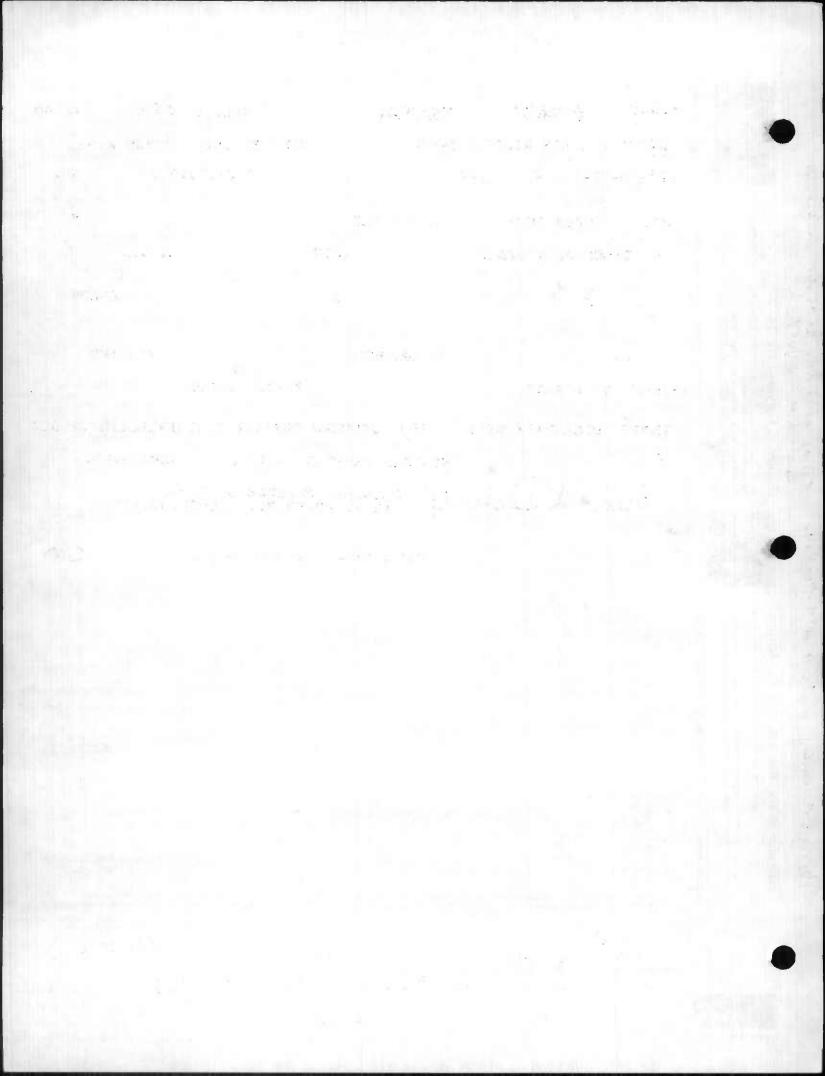
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month COOLEY 27, MARGARET JAMIESON FEB. 2000 11:00 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** SALISBURY 625 NORTH PARK DRIVE WICOMICO If Under 1 Year If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Months Deys Yrs. **Director** 242-16-7032 Usual Residence of Decedent NORTH CAROLINA 82 09/15/1917 10a, State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f ahow traumatic event, the Medical Examiner install be ricitified at 10d. Inside City Limits 1 X Yes 2 □ No Director MARYLAND WICOMICO SALISBURY 10f. Zip Code 10g. Citizen of What Country? 625 NORTH PARK DRIVE 21804 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 0 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours effer then of Health and Mentel Hygiene. 1 ☐ Never Merried 2 ☐ Married 1□ Yes 2 No þ Specify: 3⊠Widowed 4 □ Divorced WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 $5 \pm$ HOMEMAKER OWN HOME 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ANDREW JAMIESON KATHERINE HOGE 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: if Item 27 Is any injury or other tra-anse. Arhtur Cooley/Son 3843 Devonshire Drive, Salisbury, Md. 21804 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ☐ Burial 2 Cremetion 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SALISBURY CREMATORY 2/28/00 | SALISBURY, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Fecility HINMAN FUNERAL HOME MO0295 11673 SOMERSET AVENUE, PRINCESS ANNE, MD. 21853 Approximate shock, or heart failure. List only one cause on each line. Onset and Deeth **Physician** /Medical Immediate Cause (Final 710 year anseroscheosis Conclesvorcular Deven disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): -leinnd physician The law requires that the death certificete be Physician/Medicai the Due to (or es a consequence of): attending p Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Sewerel Steme & Myseparty 1 Yes 2 10 3 Probably 4 Unknown been signed I should be det by 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No. Hospital or Attending Physician: 24 hours efter death. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1□ Yes 2☑ No Other: 4 Nursing Home 5 Presidence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending Investigation 1 Yes 2 No 2 ☐ Accident within 24 hours efter death To the Funeral Director: , completely filled in by the 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, and due to the ceuse(s) end menner es steted. 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier

29c. License number

106 PINE BLURF RO LOITE 12

29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

To the P

Baltimore, Maryland 21215-0020

Box 68760.

P.0.

Records,

Division of Vital

29b. Signature and title of certifier

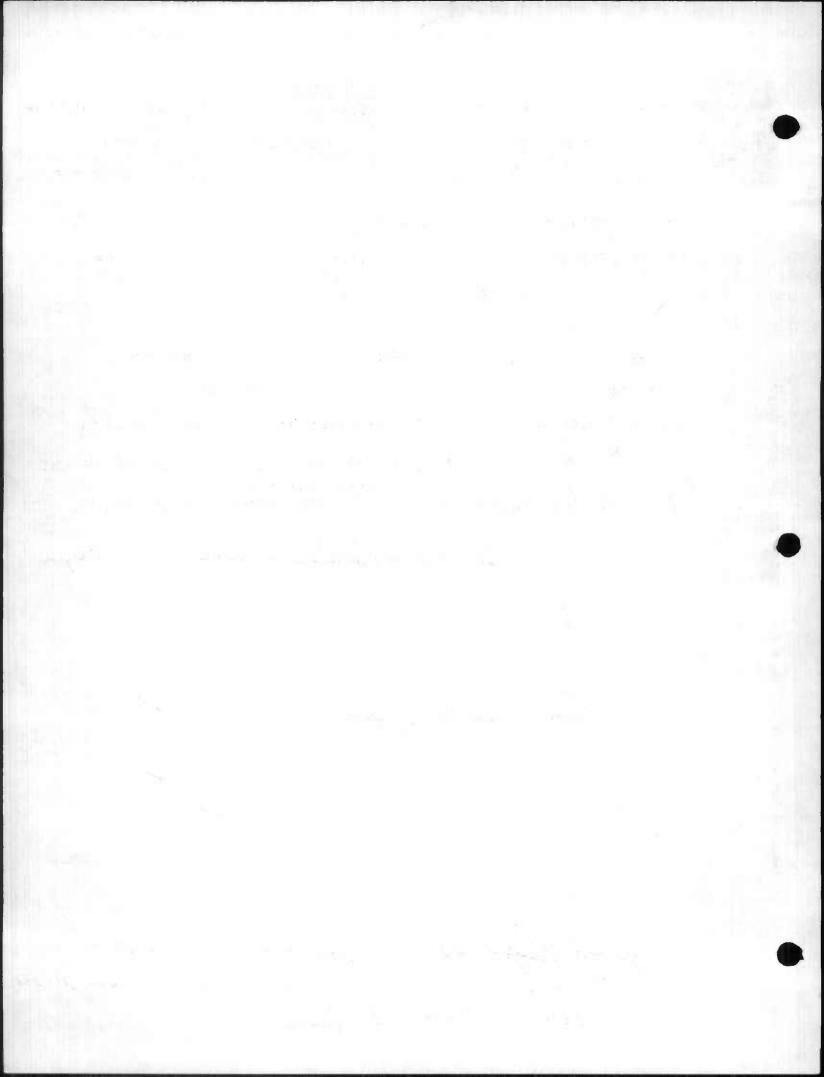
31. Date filed (Month, Day, Year)

30. Name and address of person who compared cause of death (Item 23e) (Type, Print)

PLIEFORD M.A

32. Registrer's Signeture

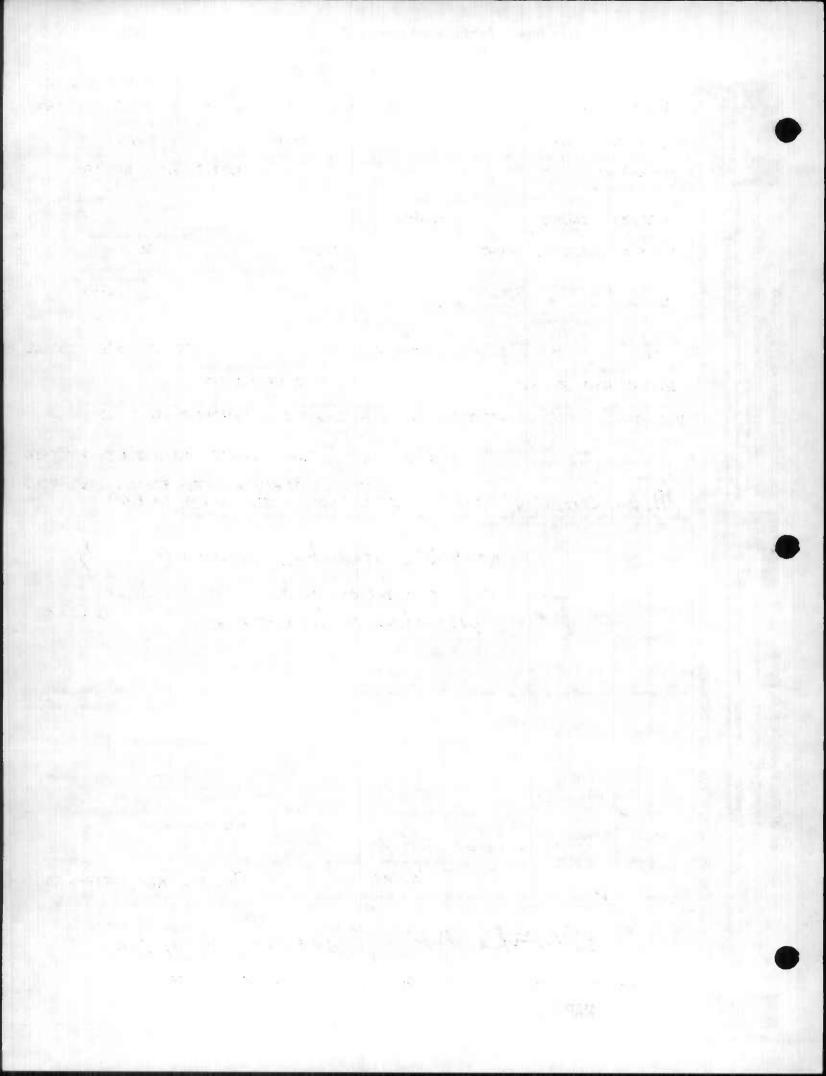
JAMES h.



State of Maryland / Department of Health and Mental Hygiene 00 08889

						10.0	Cer	tifica	te of	Death			Reg. No.		
Dhaminian	_	Decedent's Name (First, Middle	e, Last)									2. Date of De Month	ath Day	Year	3. Time of Death
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Examine	4.0	Facility Name (If not institution	, give s	treet end nu	mber)					4b. City, To	own, or Lo	ocation of Deat	4c. C	County of Dear	.h
	W	ILLIAM HILL MA	NOR							EAS	TON			TALBO	î .
Funeral Director		Social Security Number 31-10-4440	6. Sex	M 2□ F	7. Age 7	(In yrs. lesi 9	t birthday) Yrs.	If Und Months	Deys	if Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da SEPT - S	th ly. Year) 1920	9. Bird C NEV	hplace (State or Foreign puntar) YORK
2	-	sual Residence of Decedent													
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th with the Maryle 23a or 28a-f ahor unit be motified at	10	e. Street and Number 408 C GOLDSBOR	OUG:	H STRE	ET			10f. Z	ip Code 21	601				en of What Co USA	untry?
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Iryland 212: hould be filed within to Mental Hygiena. merked other than meric event, the M	Ď	JOHN GREGORY I		HUE								QUINN			
2 2 2	19	Pa. informant's Name/Relations			JGHT							el Route Numb			
other tr	20	a. Method of Disposition					e of Dispo			1	T	Date	20c. Loca	ation - City or	Town, State
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Baltimore, permit. Peges 1e Department of Hei Important: if item eny injury or othe once.	21	Signature of Funeral Service	Licanse	11 II	Ic	F.S.(o FI	ELLO	VS, H		BEIN	W & NEW			HOME, P.A.
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ox 6876(n certificate be anding physicia use as the bur		sulting in deeth) Last	L a		U	oue to (or as	s a conseq	uence of):						
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Division To the Hospital or Attention within 24 hours after deelt To the Funeral Director: completely filled in by the		De. Certifier 1 Certifyin (Check only one)	g Physi Examin	er: On the b	asis of e	examination	MON edge, death and/or inv	occurre	d at the ti	me, date er	nd plece, ath occur	and due to the red at the time.	cause(s) a	and menner a plece, and du	s stated. e to the cause(s)
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	30	Name end address of person ROBERT B. S											21601	/	
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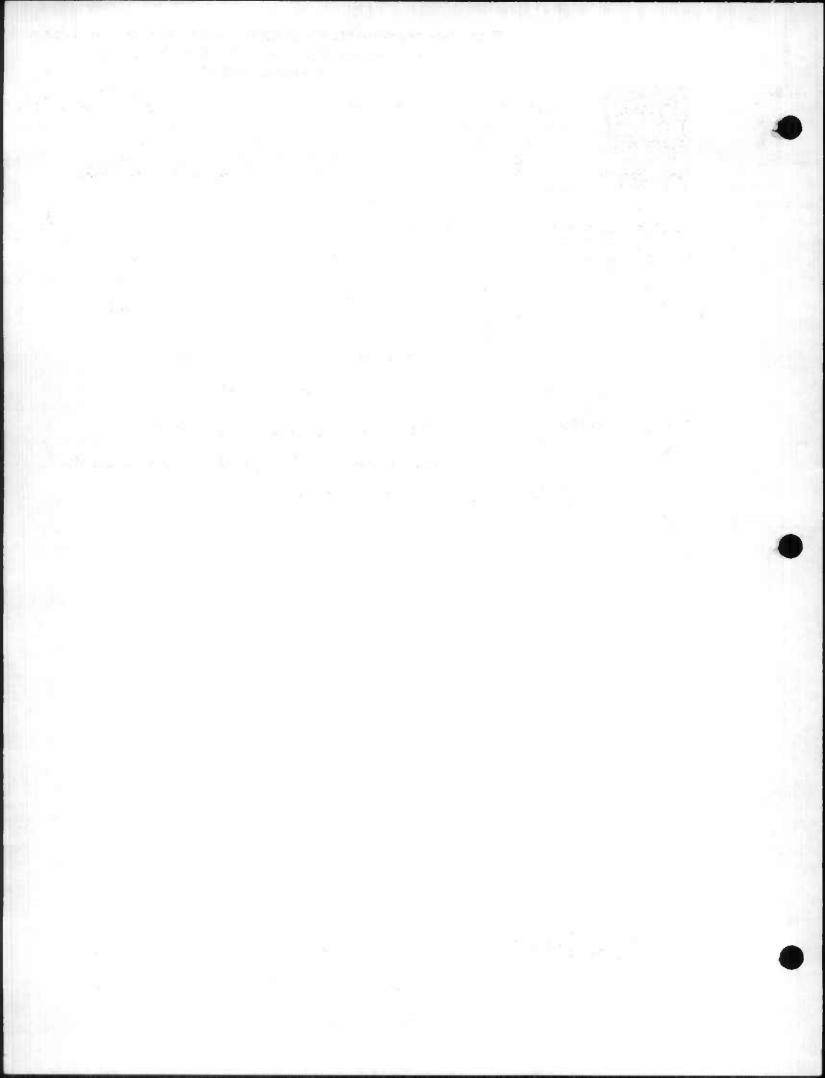
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

					Cer	tificate d	of Death		Reg. No.	00	00000	
Physician	n	1. Decedent's Nema (First, Middle, La. PAULINE		10	DOE	PCEV		2. Data of D Month		Year	3. Tima of Death 4.55 P	
/Medical	ıl -	4a. Facility Nama (If not institution, give				.36/	4h City Tourn	or Location of Dea	4	2000 County of Death		
Examiner	r	McCready Ho					CRIS	FIELD	5	SOME TO		
Funeral Director		5. Social Sacurity Number 6. S 213-18-4921 Usuel Residence of Dacadant	9X	ga (In yrs. ias 78	t birthday) Yrs.	Months De		8. Data of B (Month, 2 02/02/	lrth Dey, Year) 1922	9. Birth Cou Mary	piaca (State or Foraigi ntry) 'Land	
Meryland a-f show		10a. Stata 10b. County Maryland Somerset	t.	10c. City,	fown or Loc						10d. Inside City Limits 1 ☐ Yes 2 No	
a or 28a-f s		10e. Street and Number 8831 Lisa Lane				10f. Zip Coo			10g. Citi	zen of What Cou	intry?	
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural," or flores 23s or 28s-4 show other treumstic event, the Medical Examinators to a profitted at To Be Completed by Funeral Director	by Funer	11. Meritei Stetus 1 Nevar Marriad 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Armed Forces 1 Yes 2 M If Yas, Giva Yaar or Detas:	Ever in U,S. No	- If	Vas Decedant	of Hispanic Origin? Suben, Mexican, Pu	(Specify Yas or Nerto Rican, etc.)		14. Rece - Ameri Black, White Specify: Whi	, etc.	
ed within 72 horygiene. Nor than "naturalt, the Wedenl	pleted	15. Decedant'a Ec (Specify only highast gra	ducation da complated) Coilege (1-4or		16a. Deced (Giva I Iifa. D	lant's Usual Oc kind of work do OO NOT use re	cupetion one during most of s tired)	vorking	16b. Ki	nd of Business/Ir	ndustry	
be filed with tal Hygiene. d other than event, the		10 17. Fathar's Nama (First, Middla, Last)	_		Home	emaker	18. Mother's N	łama (First, Middl		Home Sumama)		
should be nd Mental I marked or umatic eve	0	Fitzhugh Lee Adams	S				Henrie	etta Fish	ner			
2 sho end I is me		19a. Informant's Name/Raietlonship (Type, Print)		19b. Maliin	g Address (Sti	reet and Number or	Rural Routa Num	ber, City o	r Town, Steta, Zi	p Code)	
	- 1-	George Dorsey/Son 20a. Mathod of Disposition Burial 2 Cramation 3	Ramovei from Stete	0.000	3869 e of Dispos etary, crem	Lisa La sition (Nama o netory or othar	ne, Westo place)	2000000				
permit. Pege Department o Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify 21 Someture of Funeral Service Licen	<u>-</u>	Quin		emetery	Idrass of Facility	3/7/00	Poco	moke Cit	sy, Md.	
Physician /Medical Examiner		23a Pairt1. Enter the disease, or complete, or heart failure. List only immediate Causa (Finei disease or condition resulting in death)	oilcations that cause on a cause on a cause on a ach li	GES Due to (or e	T I V I	uence of):		iac or respiretory	errest,		d. 21853 Approximeta Interval Batween Onsat and Death 10 day.	
eath certificate be executed ettending physician and for use as the burlal-transit clan/Medical Examine	medical Evaluated	The state of the s	Sequentieily list conditions, if any, leading to immediate causa. Entar Undarlying Causa (Disease or injury that Initiated events resulting in death) Last		Dua to (or a	R Y	uence of):	IERY		ろら		
thet the death of the ettended by the ettended for us	ysicia	Part II. Other eignificant conditions or	ontributing to death b	out not resulting	ng in the un	nderlying cause	givan in Part i.	23b. Dte	d tobacco	use contribute t	to the cause of peath	
os d		CVA.						10	Yes 2	□ No 3□ Pro	obably 450 Unknow	
hes been s ge 2 should								par	s an autop formad?	CX Of	lara eutopsy findings vailable prior to ompiation of cause death?	
certificate he rector, page		OF Mos ages referred to an effect								TNo 1	☐ Yas 2☐ No	
		25. Was case rafarrad to medical examinar? 1 ☐ Yas 2 ☐ No	Hospitel: 1 Impatio	ant 2 🗆 E	/Outpation	3□ DOA	Other	Daath (Check only		Other (Case	76 -1	
ation: Te	- -	27. Manner of Death 1 Matural 5 ☐ Panding 2 ☐ Accidant invastigation	28a. Dete of inju (Month, De	ıry 28	Dutpatient Bb. Tima of Injury	28c. i	njury at Work? 1 Yas 2 No	Homa 5 ☐ Ras 28d. Dascribe		- ' '	ny)	
se or Attending Pare deeth. Solution of the funer of in by the funer of in by the funer of in the funer of in the funer of interest of in		3 Suicida 6 Could not be 4 Homicide datarmined	28a. Place of In building, at	jury - At home c. (Specify)	a, farm, stre	aat, factory, off	ice	28f. Location City or To	(Street and own, State)	d Number or Rur)	al Routa Number,	
9 9 = 6		29a. Certifiar 1 Certifying Phy	ystotan: To the best	f axamination	dga, daath and/or inv	occurred at th	e tima, deta and pia	ice, and due to the courred at the time	e cause(s) ı, data and	and mannar as s piace, and dua t	stated.	
Hospital n 24 hours Funeral Metely filled		(Check only 2 Madical Exam	and manner st	etea.		astigation, In n					to the causa(s)	
To the Hospital or Attending P within 24 hours effer deeth. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	anical	(Unack only 2 Madical Exam	and manner st	eted.		astigation, In n	anse number	93		e signed (Month)	to the causa(s) Dey, Year)	
To the Hospital within 24 hours To the Fundral Completely filled	monical	enel 2 Madicai Exam	and manner st	daath (Item 2	Ba) (Type, F	29c. Lic			3-	4-20	to the cause(s) Dey, Year)	

DHMH 16 Rev 6/95

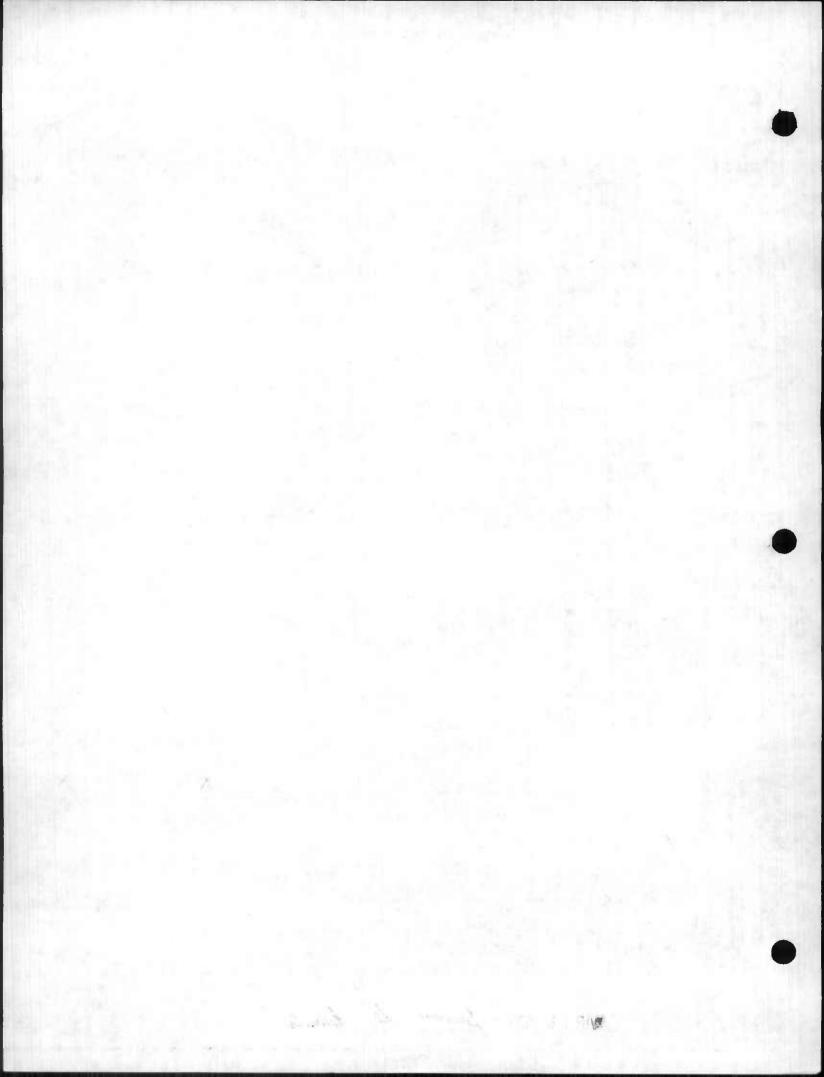


State of Maryland / Department of Health and Mental Hygiene

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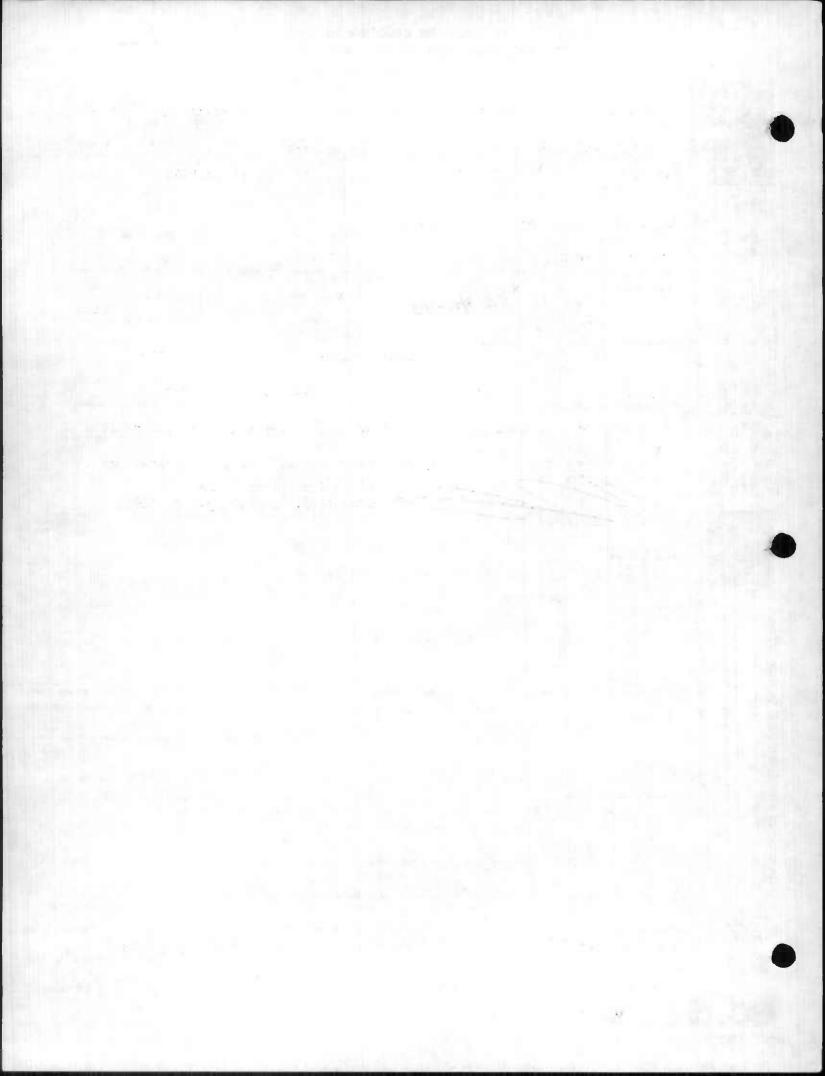
			Cei	niiica	te of	Death		Re	g. No.			10.1
	1. Decedent'a Name (First, Middle, La	ast)						ate of Death	h		3. Time of De	eath
sician	GARY ROBE	RT ELLIOTT						Nonth RCH	Day 04, 20	Year	05:32	P.M
edical	4a Facility Name (If not institution, give					b. City, Tow	vn, or Locatio		4c. County		03.32	1 011
miner	MALCOLM GROW MED					CAMD	SPRING		PRINCE	CEOE	CEIC	
			. last birthday)	If Unde	er 1 Year	If Under 2	4 Hrs. 9 D	ate of Ridh				oreian
al or	217-64-8512	1□M 2□F 45		Months	Days	Hours	Min. (A	vonth, Day.	Year) .954 W	ASHI	ce (State or f y) NGTON	, DC
7.0	Usual Residence of Decedent 10a. State 10b. County	100 0	ity, Town or Lo	e ention						110	d Inside Othe	A familia
uneral Director	10a. State 10b. County	100.0	Ry, Town Of Lo	ocation						10	d. Inside City	
recto	MARYLAND PRINCE	E GEORGE\$	C	API	rol	HEIGH	HTS				X Yes 2	□ NO
Dire	10e. Street and Number			10f. Z	ip Code			10	og. Citizen of V	Vhat Countr	y?	
uneral Di	9409 EUGENIA PA	ARK STREET			20	743			U.	S.A.		
Funer	11. Meritel Status	12. Was Decedent Ever in I Armed Forces?	J,S. 13.	Was Dece	edent of H	lispenic Orig	in? (Specify 'Puerto Ricar	Yes or No-		e - Americe		
b	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Yeer or Dates;		1 ☐ Yes		Specify:	Puerto Alcar	1, 916.)		k, White, e		
Completed	15. Decedent's E		16a. Dece	dent's Usi	ual Occup	ation during most	of working	1	16b. Kind of Bu	ısiness/indu	istry	
ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT	use retired	d)	or working	Tvi	ASHIN	GTON	SUBIII	RBA
DO.	, , (0 ,)	1	CON	STRI	JCTI	ON IN	SPEC		ANITA			
Be C	17. Father's Name (First, Middle, Last)							laiden Sumam			
0	ROBERT M	ARION ELLIOT	uti.			MAT	CAPE	יי אמ יי	IS DO	VE		
-	19a. Informant's Name/Relationship (ng Addres	s (Street				City or Town,		Code)	
	SUSAN G. ELLIO								,	-, -,		
	20a. Method of Disposition	20b.	Place of Dispo	sition (Na	5 #1		Da	ite	20c. Location -	City or Toy	m State	
	1 Burial 2 Cremetion 3	Demousl from State	cemetery, crer	matory or	other place							
	4 ☐ Donation 5 ☐ Other (Special	(y) INE	ROPOL	TTAL	V CR	EMATIC	DRY 3-	-8-00	ALEX	ANDR:	IA, VA	
8	21. Signeture of Funerel Service Lice	nsee MOO479	1/2			ss of Facility						
	1211. X - 6	DH							, P.A.			
	23a. Pert1. Enter the diseese, or corr	polications that caused the dee	th. Do not ent	ter the mo	IKIR de of dvin	K, MAR	RYLANI cardiac or res	piratory arre	est,	- 1	Approximate	
	shock, or heart failure. List only	one cause on each line.									nterval Betwe Onset and De	en eth
1	Immediete Cause (Final											
	disease or condition resulting in death)	a. ENCEPHALOPA	ATHY							1	02 DAY	S
	resulting at country	Due to	or as a consec	quence of):							
Examiner		, POSSIBLE HI	EMPATIC	INJ	URY						02 DAY	S
ше	Sequentially fist conditions,	Due to (or es a consec	quence of):							
	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events	POSSIBLE AN	MOXIC T	N.TIIR	Y						O1 DAY	P
edicai	that initiated events resulting in death) Last	C	or as a conseq								OI DILL	
2	resulting in death) Cast											
Physician/		d										
ysi	Part II. Other algnificant conditions of	contributing to death but not re	suiting in the u	inderlying	ceuse giv	en in Part I.			bacco uas co			
Ph	CIRRHOSIS							1 🗆 Yı	2 No	3 Prob	ably 4 U	iknown
by							_			0.0	alasar di Ar	41
Completed	SEIZURES							24a. Wes an perform	n autopsy ned?	ava	e autopsy fine lable prior to	
Die	SHIMORED									ot d	pletion of cau seth?	36
Eo								1 X Ye	s 2 No	1 🗆	Yes 2 N	0
0	25. Was case referred to medicet					28 Diago	of Death (Ch	/\				
100	examiner?	Hospital:	150/0 +	4 6 7 5	Oth	ar.				ns /0c = =:4		
E.S. r	1 ☐ Yes 2 ▼ No	28a. Date of Injury	ER/Outpatier 28b. Time or	-	OA	4 LI NUI	-		mce 8 Oth			
: To	27. Menner of Death	(Month, Day Year)	fnjury	м	28c. Injur Wor	k? Yes 2□N		_ 200.100 110				
	27. Menner of Death 1 Netural 5 Pending			IVI		105 2 1		.1 .00				
	1 Netural 5 ☐ Pending investigation	100					281. 1	ocation (St	reet and Numb	per or Hurai	Route Numbe	H,
	1 Netural 5 ☐ Pending	De Disco of lains At I	nome, farm, str ify)	reet, facto	ry, office			City or Town				
Certification: To	1 Netural 5 Pending investigation 3 Suicide 6 Could not be determined.	28e. Plece of Injury - At I	nome, farm, str ify)	reet, facto	ry, office					WE		
Certification:	1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying	28e. Piece of Injury - At I building, etc. (Special Injury - At I building, etc.)	ify) owledge, deetl	h occurre	d et the tir		d place, end d	Dity or Town	, State) suse(s) end ma			
edicai Certification:	1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 1 Certifying	28e. Plece of Injury - At I building, etc. (Spec	ify) owledge, deetl	h occurre	d et the tir		d place, end d	Dity or Town	, State) suse(s) end ma			
Certification:	1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only) 1 Pending investigatio 6 Could not be determined	28e. Plece of Injury - At I building, etc. (Specinysician: To the best of my kn	ify) owledge, deetl	h occurre	d et the tir	pinion, deat	d place, end d	lue to the ce	, State) suse(s) end ma	and due to	the cause(s)	
edical Certification:	1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 1 Pending investigatio 6 Could not be determined	28e. Plece of Injury - At I building, etc. (Specinysician: To the best of my kn	ify) owledge, deetl	h occurred vestigatio	d et the tir n, In my o	pinion, deatl	d place, end d h occurred at	lue to the ce the time, da	euse(s) end ma ate and plece,	and due to	the cause(s)	
edicai Certification:	1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	28e. Piece of Injury - At building, etc. (Specinysician: To the best of my knimner: On the basis of examinand manner stated.	ify) owledge, deet ation and/or in	h occurred vestigatio	d et the tirn, In my o	pinion, deatle number	d place, end d h occurred at	lue to the ce the time, de	euse(s) end mate and plece, 9d. Dete signe	and due to	the cause(s)	
edical Certification:	1 Netural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 20b. Signifiers and title of certifier 30. Name and address of person who	28e. Plece of Injury - At I building, etc. (Specinysician: To the best of my kn	m 23a) (Type,	h occurred vestigation 29	d et the tirn, In my o	pinion, death se number 000525 G/1050	d place, end de hoccurred at 33	lue to the ce the time, de	euse(s) end mate and plece, 9d. Dete signe	d (Month, E	the cause(s) Pay, Year)	

DHMH 16 Rav 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

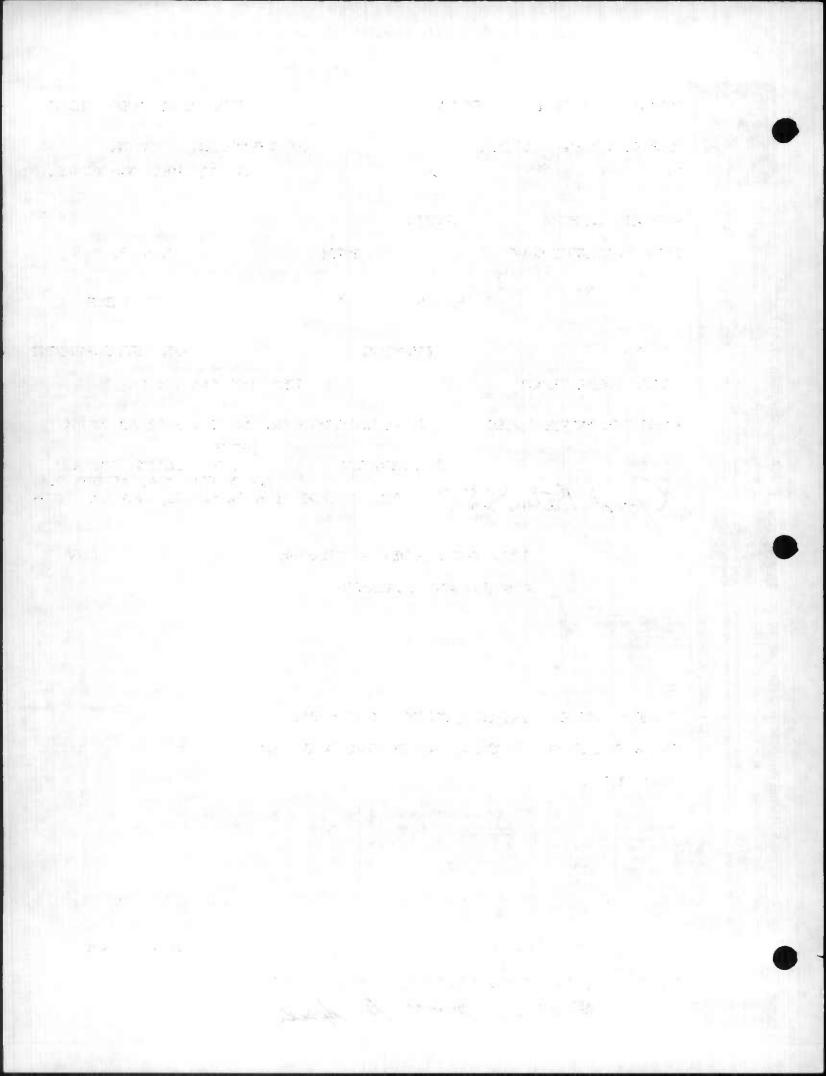
								Reg. No.		
	1. Decedent's Name (First, Middle,	Last)					2. Date of De Month	Dev	3. Year	Time of Dise
cian Iical	Charles	Edwar	cd	Fish	er.Jr.		Februa	2		21 4.1
iner	4a Fecility Name (If not institution,			2 201	01,011	4b. City, Town, or L	ocation of Deal	h 4c. County	of Death	
	302 Elliott	Dr.				Chester		Ougar	Annes	
П		6. Sex	7. Age (In yrs. le	st birthdey)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi (Month, Di		9. Birthplace Country)	(State or For
	213-60-9242	1 ⊠ M 2□ F	46	Yrs.	Months Days	Hours Min.	Aug. 3,	1 <i>y, Year)</i>	Marylar	
	Usual Residence of Decedent		70			1	Aug. J,	1773	marylai	.IQ
	10a. State 10b. County		10c. City,	Town or Loc	cation		18-27		10d. I	nside City Li
0	Marveland Ousen	A	CI						1	Yes 2
90	Maryland Queen 10e. Street end Number	Annes	Cn	ester	10f. Zip Code			10g. Citizen of \	What Country?	
Funeral Director								rog. Onzen or	What Country I	
E .	302 Elliott D				2161	-		USA		
	11. Maritel Status	Armed Fo		i. 13. V	Vas Decedent of I I Yes, specify Cub	tispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	Blac	ce - American Ir ck, White, etc.	ndian,
	1 Never Married 2 Marrie	W.W O.		, 1	☐ Yes 2 No	Specify:		Specif	v:	
	3 Widowed 4 Divorced	Year or D	ales: 8/72 - 7	/73					B1a	ck
1	15. Decedent's (Specify only highest	Education orade completed)		16a. Deced	lent's Usual Occup	pation during most of world)	king	16b. Kind of B	usiness/Industr	У
	Elementary/Secondary (0-12)	College (1	1-4or 5+)	life. E	OO NOT use retire	d)				
	9			Truc	ck Drive	c		Unknov	m	
	17. Father's Neme (First, Middle, L.	ast)				18. Mother's Nam	e (First, Middle	, Maiden Suman	ne)	
0	Harvoy	Fishe	er			Florence		Hutchir	15	
	t9a. Informant's Name/Relationshi			19b. Mailin	g Address (Street	and Number or Ru	ral Route Num!			(e)
	Florence Jones 20a. Method of Disposition	, Mother	20h Pl	325 S	State St.	, Steven	sville,	Maryland	1 21666 City or Town,	State
	1 Burial 2 Cremation	3 Removal from	0.00	metery, crem	natory or other pla	ce)	Date	200. Ebbattori	City of Town,	State
	4 Donation 5 Other (Spe			yland	Veterans	cem.	3/6/00	Beulah,	Mary1	and
	21. Signature of Funeral Brivide Li	censes			Name and Addre		1 77			
	1//	/_	_	- Total		ith Funer		1 01//		
	23a, Part1, Enter the diamest of c	omplications that	mused the death.			687, Easton			App	proximete
	23a. Part1. Enter the diameter ahock, or heart failure. List o	nly one ceuse on e	ach line.						tnte	erval Between
	Immediete Ceuse (Finai		OID							
	disease or condition resulting In death)	a	HIV:	5						
			Due to (or	es e conseq	uence of):					
		b								
5	Sequentially list conditions,		Due to (or	es e conseq	uence of):					
Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events									
Ica	that initiated events resulting in death) Lest	C	Due to (or	as a consequ	uence of):					
/Medical	and an angent post								1	
6 !		d								
		e contributing to de	ath but not recul	ting In the un	derlying cause of	ven in Pert I	23h Did	tobacco use co	entribute to the	cause of d
	Part II. Other significant condition	s contributing to de	eath but not resul	ting In the ur	nderlying ceuse gi	ven in Pert I.		tobacco use co		
Physician		s contributing to de	eath but not resul	ting In the ur	nderlying ceuse gi	ven in Pert I.		tobacco uae co Yee 2□ No	antribute to the	
by Physician		s contributing to de	eath but not resul	ting In the ur	nderlying ceuse gi	ven in Pert I.	10	Yee 2□ No	3 Probabl	y 4 ⊘ - U n
by Physician		s contributing to de	eath but not resu	ting In the ur	nderlying ceuse gi	ven in Pert I.	1 [3 Probable	y 4 24m
Dy riiyaiciai		s contributing to de	eath but not resu	ting In the un	nderlying ceuse gi	ven in Pert I.	1 [Yee 2 No	3 Probable	y 4 24m
J y y		s contributing to de	eath but not resu	ting In the ur	nderlying ceuse gi	ven in Pert I.	1 Z4a. Wa	Yee 2 No	3 Probable 24b. Were a availab comple of deat	utopsy find le prior to ation of ceus h?
museful (a societimos	Part II. Other significant condition 25. Was case referred to medical	es contributing to de	eath but not resu	ting In the ur	nderlying ceuse gi	ven in Pert I. 26. Place of Dea	24a. Wa:	Yee 2□No s an autopsy ormed? Yes 2☑No	3 Probable 24b. Were a availab comple of deat	y 4 24mi
o Be Completed by Physiciar	Part II. Other significant condition 25. Was cese referred to medical examiner?	Mossilati			0.00	26. Place of Dea	24a. War peri	Yee 2□ No s an autopsy ormed? Yes 2☑ No one)	3 Probable 24b. Were a availab comple of deat 1 Ye	utopsy find le prior to ation of ceus h?
To Be Completed by Physician	Part II. Other significant condition 25. Was case referred to medical	Hospital: 1 🗆	Inpatient 2 E	R/Outpatien 28b. Time of	t 3□ DOA Ot	26. Place of Dea her: 4□ Nursing H	24a. Warperli	Yee 2□No s an autopsy ormed? Yes 2☑No	3 Probable 24b. Were a availab comple of deat 1 Ye	utopsy find le prior to ation of ceus h?
To Be Completed by Physician	Part II. Other significant condition 25. Was cese referred to medical examiner? 1 Yes 2 1 No 27. Manner of Death 1 Deforai 5 Pending	Hospital: 1 ☐ 28a. Date (Mon.	Inpatient 2□E	R/Outpatien	t 3 DOA Ot	26. Place of Dea her: 4□ Nursing H	24a. Warperli	Yes 2 No s an autopsy ormed? Yes 2 No one) idence 6 Ott	3 Probable 24b. Were a availab comple of deat 1 Ye	utopsy find le prior to ation of ceus h?
l o be completed by Physician	25. Was cese referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Defural 5 Pending Investige 2 Accident 3 Sulcide 6 Could no	Hospital: 1 28a. Date (Mon	Inpatient 2 E of injury th, Day Year)	R/Outpatien 28b. Time of Injury	t 3 DOA O1	26. Place of Dea her: 4□ Nursing H ry at rk?	24a. Wa: perl 1 □ th (Check only) ome 5 □ Fes 28d. Describe	Yes 2 No Yes 2 No Yes 2 No One) idence 6 Oth how injury occur	3 Probable 24b. Were a availab comple of deat 1 Ye ner (Specify)	uttopsy find le prior to stion of ceut h?
To Be Completed by Physician	Part II. Other significant condition 25. Was cese referred to medical examiner? 1 Yes 2 Nanner of Death 1 Natural 5 Pending Investige	Hospital: 1 1 28a. Date (Mon.) at be 28e. Place	Inpatient 2 E of injury th, Day Year)	R/Outpation 28b. Time of Injury	t 3 DOA Ot	26. Place of Dea her: 4□ Nursing H ry at rk?	24a. Warperl 1 th (Check only ome 5 Pres 28d. Describe	Yes 2 No s an autopsy ormed? Yes 2 No one) idence 6 Ott	3 Probable 24b. Were a availab comple of deat 1 Ye ner (Specify)	uttopsy find le prior to stion of ceus h?
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Certification: 10 Be Completed by Physician	25. Was cese referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Netural 2 Accident 3 Sulcide 6 Could not determine.	Hospital: 1 28a. Date (Mon) to be led 28e. Piace buildi	Inpatient 2 E of injury th, Day Year) of Injury - At hor ng, etc. (Specify)	ER/Outpatien 28b. Time of Injury ne, farm, stre	t 3 DOA Ot 28c. Inju Wo M 1 Deet, factory, office	26. Place of Dea her: 4□ Nursing H ry at rk? I Yes 2□ No	24a. Wa: perf	Yes 2 No san autopsy ormed? Yes 2 No one) idence 6 Oth how injury occur (Street and Numium, State)	3 Probable 24b. Were a availab comple of deat 1 Ve her (Specify) rred ber or Rural Ro	y 4 2 units sudopsy find the prior to station of ceus h?
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hysician	DONALD FREDER		ч			Month FEBRUAR	Dey	Year 2000	15:40
Medical kaminer	4e Facility Neme (If not institution, give		,11		4b. City, Town, or		4c. County		10.40
ral tor	CALVERT MEMORIAL 5. Social Security Number 8. S 578–48–2657 1		s. lest birthday) 62 Yrs.	If Under 1 Year Months Deys	PRINCE I I Under 24 Hr Hours	MOnth, Day,		VERT 9. Birtho Coun WASH	lace (State or Foreign
rector	Usuel Residence of Decedent 10e. State 10b. County MARYLAND CALVERT		ity, Town or Lo	ocation				1	0d. Inside City Limits 1 ☐ Yes 23 No
ral Director	10e. Street and Number	De	AVILLUL	10f. Zip Code		10	Og. Citizen of \	Whet Cour	ntry?
ia C	11714 RIVERSHORE	DRIVE		20754	1		U.S.	Α.	
by Funeral	11. Maritel Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedent Ever in Armed Forces? 1 X Yes 2 No If Yes, Give 7 59-		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Specify Yes or No- to Rican, etc.)	Blee	ck, White,	etc.
	15. Decedent's Ed (Specify only highest gre	lucetion	16a, Dece	dent's Usuel Occup	pation during most of wo	deina	16b. Kind of B		
Completed	Elementery/Secondary (0-12)	College (1-4or 5+)		skind of work done DO NOT use retire IGHTER	d)		o.C. FI	RE D	EPARTMENT
To Be	17. Father's Neme (First, Middle, Last) FLOYD SAMUEL FRE					me (First, Middle, A IINE DORA			
	19a, Informent's Neme/Relationship (1	Type, Print)	19b. Maili	ing Address (Stree	t end Number or R	urel Route Number	City or Town,	Stete, Zip	Code)
	FRANCES D. FRENCH 20e. Method of Disposition 1 Buriel 2 Scremation 3 D	20b.	Place of Disp	4 RIVERSE osition (Neme of metory or other pla		DUNKIRK, Dete MARCH	MARYLA 20c. Location		20754 own, Stete
any injury or pace.	4 Donetion 5 Other (Specify 21. Signeture of Funeral Service Ligan	1)		EMATORY 2. Name and Addre	1 2 111	7,2000 CE FUNERAL			
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cian	23a. Part. Enter the disease, or compared to the compared to t	one ceuse on each line.	3(II. DO 110) 911	ter the mode or dyr	ng, such es cardio	c or respiratory arre	,		Intervel Between Onset end Death
cal	Immediate Ceuse (Final disease or condition	INTRACTABLE	CARDI.	AC ARRHYT	THMIAS			1	HOURS
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al Examiner	Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or es e conse	quence of):					
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Phys	Pert II. Other significant conditions of LYMPHOMA, DIABETE						s 2 No		the cause of death? bably 4 ☐ Unknown
leted by	PULMONARY DISEASE	- CHRONIC RE	NAL FA	ILURE, CO	NGESTIVE	24e. Wes e		ev	ere autopsy findings eilable prior to empletion of cause
Completed	HEART FAILURE					1 □ Ye	s 2√2 No	of	death? ☐ Yes 2 ☐ No
Be C	25. Wes cese referred to medical examiner?				26. Plece of De	eth (Check only on			
F 5	exeminer r 1 ☐ Yes 2 🔯 No 27. Menner of Deeth	Hospitel: 120mpatient 20 28e. Dete of Injury	28b. Time o	IN SLI DUA		Home 5 Reside			(y)
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Comple	29b. Signeture and title of certifier.	Block		29c. Licen	se number		9d. Date signe		
	20 Name and Advance of Section 1	completed dues of death (III	02a) /Tuna	Deint				,	

20+1

State Registrar JOHN WEIGEL, M.D. PRINCE FREDERICK, MARYLAND



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Kenneth Purnell Franklin February 28 2000 4:32 a.m. /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1⊠M 2□ F Months Deys Hours Yrs. 83 Director 214 16 5800 Nov 20, 1916 Mary land Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location. 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours efter death with the Marylan nearl of Heelih and Mental Hygiene. In this file may a ranked other than "natural; or frems 23a or 28a-f show ary or other traumatic avant, the teacest Engine mast to invite a say. Anne Arundel Tracy's Landing 1 ☐ Yes 2 No Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6038 Franklin Gibson Road 20779 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Yeer or Detes: 1941–45 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: white by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) carpenter Federal Govt. 12 17. Father's Neme (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Robert T Franklin Thomas Nannie Nutwell 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Heelth Important: If Item 27 any injury or other tr ance. Mary J. Franklin / wife same as # 10 above 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stata 1 Buriel 2 □ Cremetion 3 □ Removel from Stete 4 □ Donetion 5 □ Other (Specify) St. James Parish Cemetery 3-2-00 Lothian, Maryland 21. Signature of Funerel Service Licania 22. Name and Address of Facility 20736 Rausch Funeral Home, P.A., Owings, MD 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervet Between Onset and Death **Physician** Myo avdial Inferition immediate Cause (Final disease or condition resulting in death) /Medical Examiner Congesque Kegut failure 4 yrs Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or trijury that initiated events resulting In deeth) Last Due to (or es e consequença of): and Pailure Inonly physician sthe burial Box 68760, Physiclan/Medical Due to (or es a consequence of) 950 signed by the a P.O. 23b. Did tobacco use contribute to the cause of death? Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Menner of Death 28d. Describe how injury occurred 28e. Dete of tnjury (Month, Dey Year) 28b. Time of 28c. Injury et Work? Attending 5 Pending n 24 hours after death.

In Funeral Director: After the function between the function of the f investigation 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Pleca of tnjury - At home, term, street, tactory, office building, etc. (Specify) 4 Homicide 6 Hospital 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 124,18

State Registrar 1340 Wensville

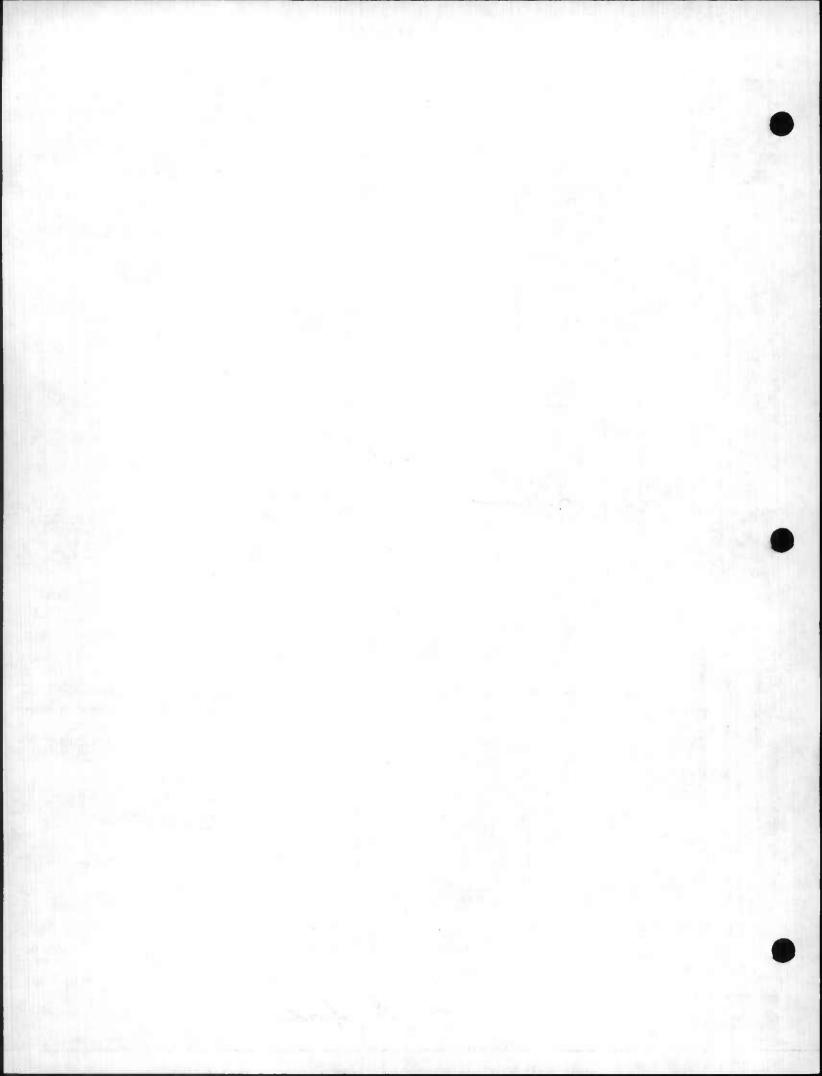
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32. Registrar's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

25,2000

West



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Harper th 4c. County of Deeth Erasia March /Medical 6:15PM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Brandywine Ch
If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Dey, Year) Charles 5. Social Security Number OW et Sex Road 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** 1□ M 2€ F Yrs. 214-28-8864 Director November 16,15 Missouri 84 Usuel Residence of Decedent with the Meryland permit Pages 1 and 2 should be filed within 72 hours after death with the Merylan Department of Health and Mentel Hygiene. Importants II than 27 is marked other than "natural", or Nems 23s or 28s-f show minery or other traumatic event, the Mexical Examiner must be notified at and the 10e State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Doyes 2 □ No Directo Maryland Prince Georges Brandywine 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 13632 Tower Road 20613 U.S.A. 14. Race - American Indien. 12. Wes Decedent Ever In U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Etementery/Secondary (0-12) College (1-4or 5+) 12 Homemaker Domestic 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middle, Last) Jerry Goodin Della Bradshaw 19b. Melting Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) Doris Faulk / Daughter8749 Valley Dr. Waldorf Maryland 20603

20a. Method of Disposition

20b. Place of Disposition (Name of cemetery, cremetory or other place)

20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Brandywine MD House Prayer Ch#2 3/11/00 21. Signature of Funeral Service Licenses 22. Neme end Address of Fecility mou/9/ Adams Funeral Home P.A Aguasco MD 20608 ations thet ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, cause on each line. 23e. Pert1. Enty the diseese shock, or weart feilure. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in deeth) 1cars . Multiple Myeloma Examiner Due to (or es e consequence of) Examiner end i-transit The law requires that the death certificate be executed Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury physician er s the bunel-to Division of Vital Records, P.O. Box 68760, Physician/Medical thet initieted events resulting in death) Last Due to (or as e consequence of): 80 attending p signed by the a 23b. Did tobacco use contribute to the cause of death? Pert fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably Unknown þ 24b. Were eutopsy findings available prior to been signal 24e. Wes en eutopsy performed? Completed completion of ceuse of deeth? certificate hes b director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home Residence 6 Other (Specify) 1 Tes 2 No 01 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending 1 Yes 2 No investigetion deeth. 2 Accident within 24 hours efter deeth To the Funeral Director: , completely filled in by the 6 Could not be 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Phyaician: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the ceuse(s) and menner es steted.

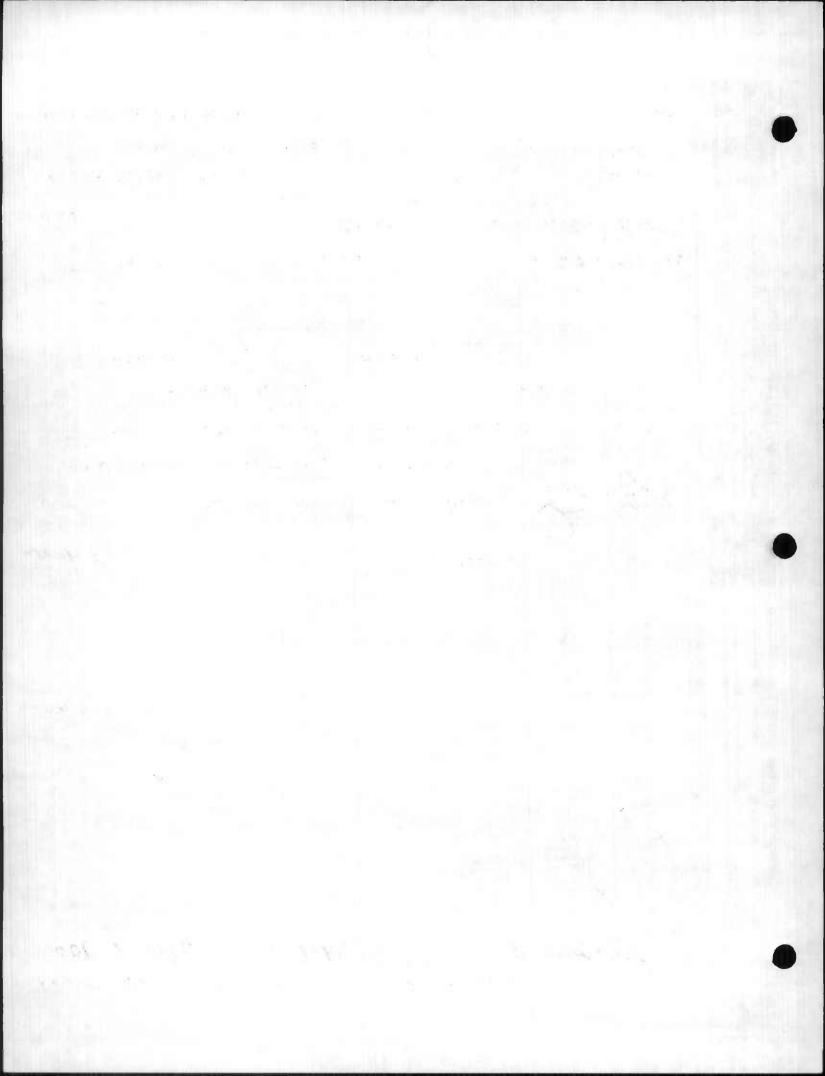
— Madical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29a. Certifier edicai (Check only one) 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifie 30. Name end eddress person who completed ceuse of death (Item 23a) (Type, Print) WALDORF MD 20603 31. Date filed (Month, Day, Year) 32. Registrer's Signeture

Registrar

State

MAR 08 2000

Deper



State of Maryland / Department of Health and Mental Hygiene 10 08896

			C	ertificate of	f Death	R	eg. No.	00000
	1. Decedent's Name (First, Middle, L.	nst)		1, 12 20		2. Date of Dea Month	th Day Year	3. Time of Deeth
Physician /Medical	WILLIAM	HENRY		7F-12 5	BEAN	FEBRUA		
Examiner	4a Facility Name (If not institution, gi	ve street end number)			4b. City, Town, o	r Location of Death	4c. County of De	ath
	Calvert Memorial				Prince F		Calver	
Funeral Director	216-10-3384	Sex 1	s. last birthde Yrs	Months Day	r If Under 24 H s Hours Mi	Month Day	9. B 6, 1916 Ma	irthpleca (State or Foreign Country) ryland
2	Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town or	Location				10d. Inside City Limits
a Maryta Mart sho diffied at	Maryland Calv		Dow					1 □ Yes 2 No
th with the Ma 23e or 28e-fe ust be notified	10e. Street and Number 50 Bean Road			10f. Zip Code	0629		log. Citizen of What (
ours after death v art, or there 23s Examinet must by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2(X)No If Yes, Give Year or Dates:	U,S.	3. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 💢 N		(Specify Yes or No- erto Rican, etc.)	14. Raca - An Black, Wh Specify: B1	
72 ho natur fisel	15. Decedent's E (Specify only highest g	ducation	16a. De	cedent's Usual Occ	upation	orkina	16b. Kind of Busines	s/Industry
ed within 72 ho ygiene. er than "natur if, the Medical. Completed	Elementary/Secondery (0-12)	College (1-4or 5+)		ive kind of work don e. DO NOT use reti Waterman	red)		Seafood	
	17. Father's Name (First, Middle, Las	()			18. Mother's N	eme (First, Middle,	Maiden Sumame)	
Mental H srked off afte sver	John	Bean			Amelia		Wise	
and M	19a. Informant's Name/Relationship	(Type, Print)	19b. M	eiling Address (Stre	et and Number or	Rural Route Numbe	r, City or Town, State	, Zip Code)
27 19 2	Gertrude B. Bean	/Wife	P.0	. Box 34	Dow	e11, MD 2	0629	
Pages 1 a ent of He at If Item ry or othe	20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	Removal from State	cametery, o	sposition (Name of crematory or other p		Date 3/6/00	20c. Location - City of Lusby, MD	or Town, State
Departm Departm Importer any inju	21. Signature of Funeral Service Lice			22. Name and Add	Iress of Facility S	ewell Fun	eral Home	ek, MD 20678
	23a. Part1. Enter the disease, or con shock, or heart feilure. List on	mplications that caused the de						Approximate Interval Between
Physician	snock, or neart reliure. List onr							Onset and Death
/Medical	Immediate Cause (Final disease or condition	· Card	ia	c A	RRH'	YTHMI	A	Few minul
Examiner 5	resulting in death)	CORON	(or as a con	sequence of):	RTERY	y Dis	EASE	Few years
axecuted in and ial-transit	Sequestially list conditions	D		sequenca of):	-(1 0
EXE	if any, leading to Immediate cause. Enter Underlying		(1)					
ntificate be executed ng physicien and s as the burial-transit Medical Examir	Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c. Due to	(or as a con	sequence of):				
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death cer e ettendir od for use siclan/A	Part II. Other significant conditions	contributing to don't but not a	acutting in th	o undodulne enue	niven in Dart I	23h Did t	obacco use contribu	ite to the cause of death?
ed by the detached detached			A .	7	given in Fatti.	1 🗆 1	. /	Probably 4 Unknown
y P	OLD MYOU	rdial.	9770	reun.		_	24110	· robebly 4 dinalowii
The law requires that the death certinate has been signed by the ettending page 2 should be detached for use a Completed by Physician/M	Carcinoma	rdial Prost	ale		They it	24a. Was a	an autopsy 24t	b. Were autopsy findings available prior to completion of cause of death?
The law sate has be page 2 s						400	es 2DNo	1 ☐ Yes 2 ☐ No
certificate rector, pag	OF Man once referred to madical				TA DISTANCE	1 D Y		10 165 20 100
ysician: s certific director,	25. Was case referred to medical examiner?	Hospital:	Mania		Whore	eath (Check only o		
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year MARCH 2000 2:30 am EILEEN RAYE HENSLEY 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 21 Patuxent Mobile Estates Lothian Anne Arundel If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Days Min. Hours 1□M 2♥F Months 577 44 8261 Wash., D.C. August 7, 1935 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Anne Arundel Lothian 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20711 United States 21 Patuxent Mobile Estates 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Merried 2 Married 1 ☐ Yes 2 No 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) automotive 12 Accountant 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First Middle Maiden Sumame) Helen V. Ward Mitchell 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald E. Hensley / husband same as 10 20b. Plece of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 Cremetion 3 Removel from State 4 Donetion 5 Other (Specify) Metropolitan Crematory 3/4/00 Alexandria, Virginia 22. Name and Address of Facility 21. Signeture of Funeral Service Licental Rausch Funeral Home, P.A. P.O. Box 100, Owings, Maryland 20736 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only app cause on each line. Marthy (ancer Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or es e consequence of): Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. Stete

Funeral

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Examiner Physician/Medicai þ Completed Be Certification: To

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Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28e. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

29b. Signeture and title of certifier 9.

29c. License number 12146 29d. Date signed (Month, Day, Year) 3-1-2000

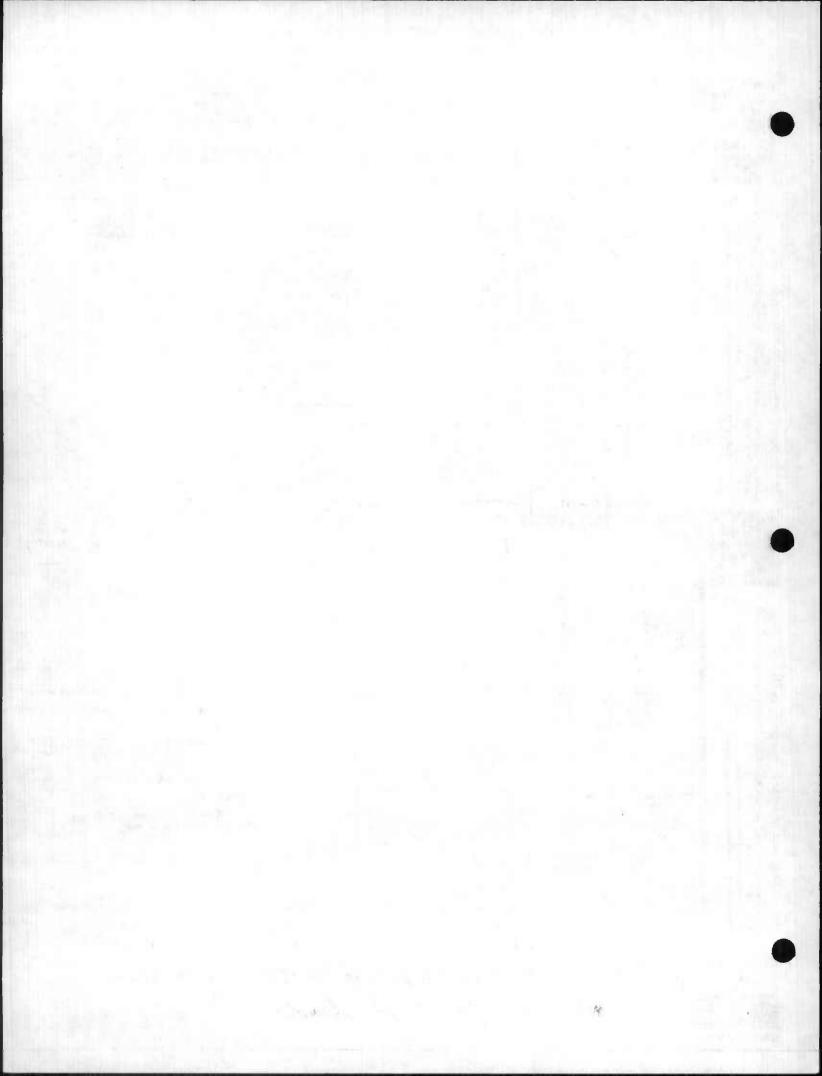
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRUCE A. SILVER, WD 110 HOSPITHE RD., SV. 110, PRINCE FREDERICK, WD. 20678

State Registrar

Medical

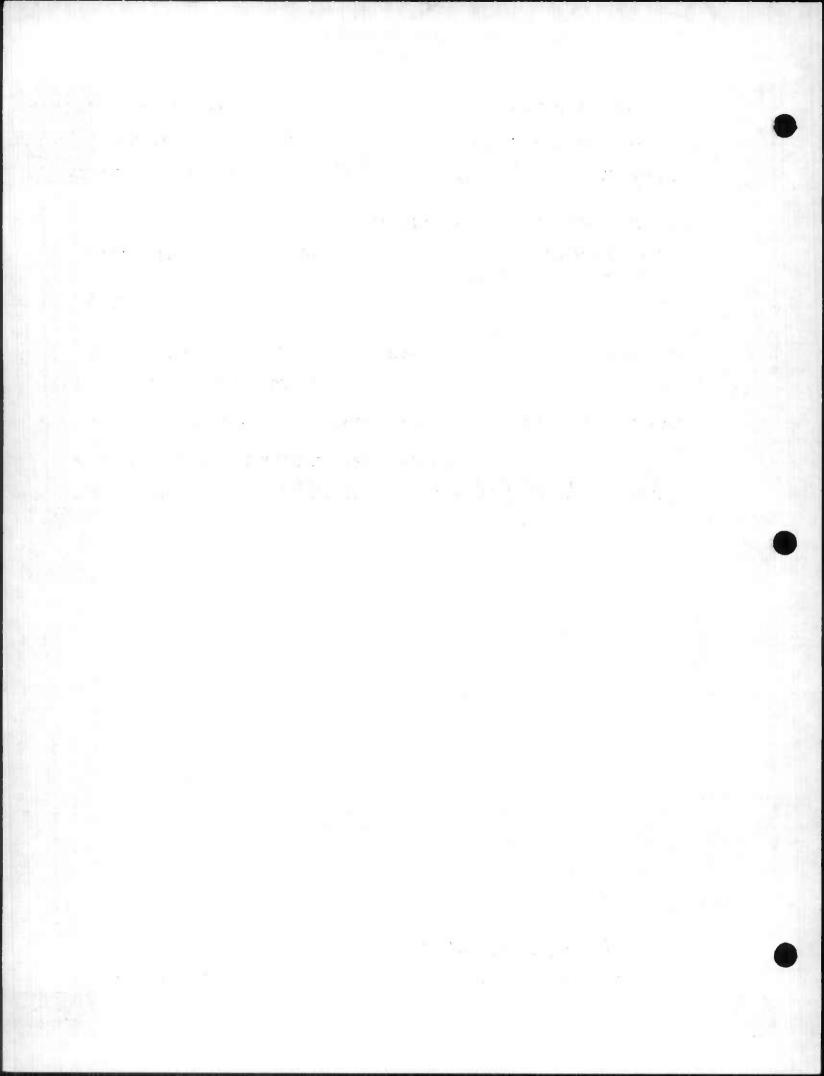
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State of Maryland / Department of Health and Mental Hygiene

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		WALDORF HEALTHC	ARE CENT	ER				WALI	OORF		CHA	RLES		
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State of Maryland / Department of Health and Mental Hygiene 00 08899

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** William J. Jones, Jr. 6:05 Am March 2005 /Medical 4e. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Dorchester General Hospital Cambridge Dorchester If Under 1 Yeer If Under 24 Hrs.
Months Days Hours Min. 8. Deta of Birth (Month, Day, Year)
Feb. 12, 1912

9. Birthpleca (Stata or Country)
Maryland Birthpleca (Stata or Foreign Country) 5. Sociel Sacurity Number 7. Aga (In yrs. last birthdey) **Funeral** 1₩ 2□ F 88 Yrs 216-03-4194 Director Usuai Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hydiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-4 show any injury or other traumatic event, the Medical Examinet must be notified at once. 10a. Steta 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Wicomico Delmar 1 Vas 2 □ No Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8706 Bi-State Blvd. 21875 United States Funeral 12. Was Decedent Ever in U.S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexicen, Puarto Ricen, etc.) 14. Race - American Indian, 11. Maritai Status Black. White, etc. Armed Forces: 1 A 3 - 4 5 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No þ Specify: White 3√GWidowed 4 □ Divorced Completed 16a. Decedent's Usuei Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Attendant Hospital 8 17. Fathar's Nama (First, Middla, Last) 16. Mother's Neme (First, Middle, Melden Surname) William J. Jones, Sr. Lillie Todd 10 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 8706 Bi-State Blvd., Delmar, MD 21875 James L. Jones/Son 20b. Piece of Disposition (Neme of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a, Mathod of Disposition Dete 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify) Hurlock, Maryland Unity-Washington Cem. 3/12 21. Signature of Funerei Sarvice Licensee 22. Nama and Address of Facility Milas Framptom-Hawkins-Eskow Funeral Home, PA Likow 23a. Pert1. Entar the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest,

Approximate Interval Between the following in the control of the control Onset and Death Physician /Medical immediate Ceuse (Final diseese or condition resulting in death) Due to (or es a consequence of): Hours Examiner Physician/Medical Examiner Polindrary Oreace physician and s the burial-transit The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediata ceuse. Enter Underlying Cause (Disaase or Injury Division of Vital Records, P.O. Box 68760, c. Corostara Bitera D. seese thet initieted events resulting in daath) Last a Hypertension ears use for signed by the a d be detached f Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Naa 2 No 3 Probably 4 Unknown Maryoseal þ 24b. Wara autopsy findings aveileble prior to completion of cause of death? 24a. Wes an autopsy performed? Completed s certificate has t director, page 2 s 2 10 No 1 ☐ Yes 2 ☑ No or Attending Physician: 25. Wes cese referred to medicei examiner? 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 1 ☐ inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA After this 28a. Dete of injury (Month, Dey Year) 27, Manner of Deeth 28d. Describe how injury occurred 28b. Tima of 28c. injury at Work? 1 Neturei ve Hospital or Attending in 24 hours after death. The Funeral Director: After pletely filled in by the fur-5 Panding investigation 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28a. Place of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 🗹 Certifying Physician: To the best of my knowledga, deeth occurred et tha tima, dete and piace, and dua to tha causa(s) and menner as stated. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi 2 Medical Examinar: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and menner steted. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and address of person who completed cause of deeth (item 23a) (Type, Print) V0053198 MARK E. Velache, MA 503 BYRNST. Site 1 Cambridge MD 21613

State Registrar

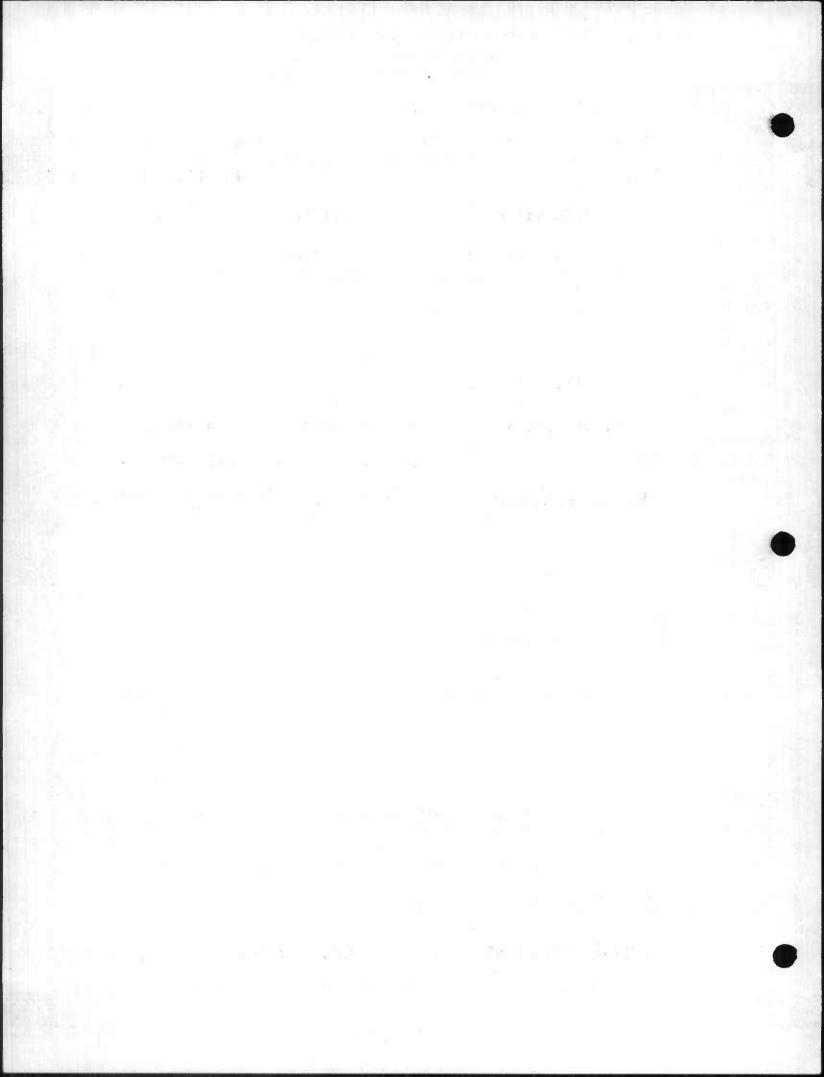
DHMH 16 Ray 6/95

MAR # 0 2000

31. Date filed (Month, Dey, Year)

32. Registrer's Signeture

Service G. Sparks



	st)		rtificate of		2. Date of De	Reg. No.	3	3. Tima of Death
Winnie Belle B	D LeComp	to			Month March	1, 200	Yaar	8:00 am
4a. Facility Name (if not institution, give				4b. City, Town, or	Location of Deat			0.00 an
214 Bay Counti		0		Cambr		_	rches	ter
5. Social Security Number 6. S		(In yrs. last birthday)	If Undar 1 Yaar		s. 8. Date of Bir	th		
215-44-5972 Usual Residence of Decedent	I M ONE	8 Yrs.	Months Days	Hours Min	May 2	o, 1921	Mar Mar	e (State or Fore) yland
10a. Stata 10b. County		10c. City, Town or Lo					10d.	Inside City Lim
	hester		Cambrid	lge				1 Yes 2□I
10e. Straet and Number			10f. Zip Code			10g. Citizen of \		?
214 Bay Counti			216			U.S	. A .	
11. Marital Status 1 Never Married 2 Married	12. Was Decedent E- Armed Forces? 1 Yes 2 No.	0	Vas Decedent of H f Yes, specify Cub I □ Yas 2X No	Hispenic Origin? (an, Mexican, Pua Specify:	Specify Yes or No irto Rican, atc.)	Specify	a - Amarican ck, White, etc	
3 XWidowed 4 □ Divorcad	Yaar or Dates:						Whi	te
3 Widowed 4 Divorcad 15. Decedent's Ed (Specify only highest gra Elementery/Secondary (0-12) 12	ducation ada com <i>pleted)</i>	16a. Deced	lent's Usual Occup kind of work done OO NOT use retire	pation during most of we	orking	16b. Kind of B	usiness/Indus	stry
Elementery/Secondary (0-12)	College (1-4or 5+	-)					3	
12	1	Funer	al & Tou					Couris
17. Father's Name (First, Middle, Last)					ame (First, Middle		1a <i>)</i>	
Thomas Gillis					hia Tur			
19a. Informant's Name/Relationship (7	Type, Print) Son/	19b. Mailin	g Address (Street	and Number or F	Rural Route Numb	er, City or Town,	State, Zip Co	ode)
Granville Robert	t LeCompte	e 2 Sh	nawnee	Drive,				
20a. Method of Disposition 1 💆 Burial 2 🗆 Cremation 3 🗆	Removal from State	20b. Pleca of Dispo camatery, cren	sition (Name of natory or other pla	ca)	Date	20c. Location -	City or Town	
4 Donation 5 Other (Specif)		ChristEp	iscopal	Gravey	ard3-4	Cambr	idge,	MD
21. Signature of Funeral Service Licen	1588 R		Nama and Addre					
23a. Parti. Enter the disease, or comp shock, or heart fallure. List only	at 10 mi		08 High					oproximate
Immediate Cause (Finel diseasa or condition resulting in death)	. Stroke						1	
	6. Hypen	Due to (or as e conseq						inutes,
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last	6. Hypes	Due to (or as e conseq	uence of):					year
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Registrar **DHMH 16 Rev 6/95**

Physici /Medic Exami

Funerai Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hypiene. Important: If item 27 is marked other than "natural", or flams 23a or 28a-f show any highry or other traumatic event, the Medical Examiner must be notified at odds.

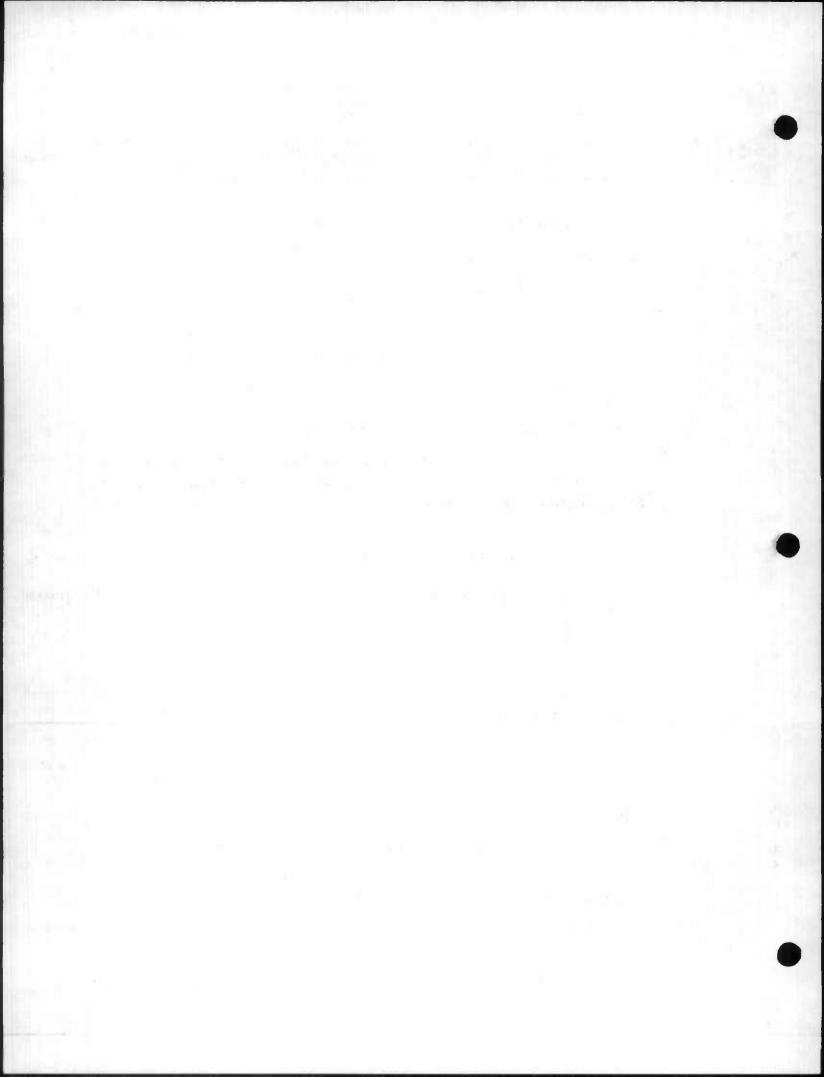
Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the deeth certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the ettending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

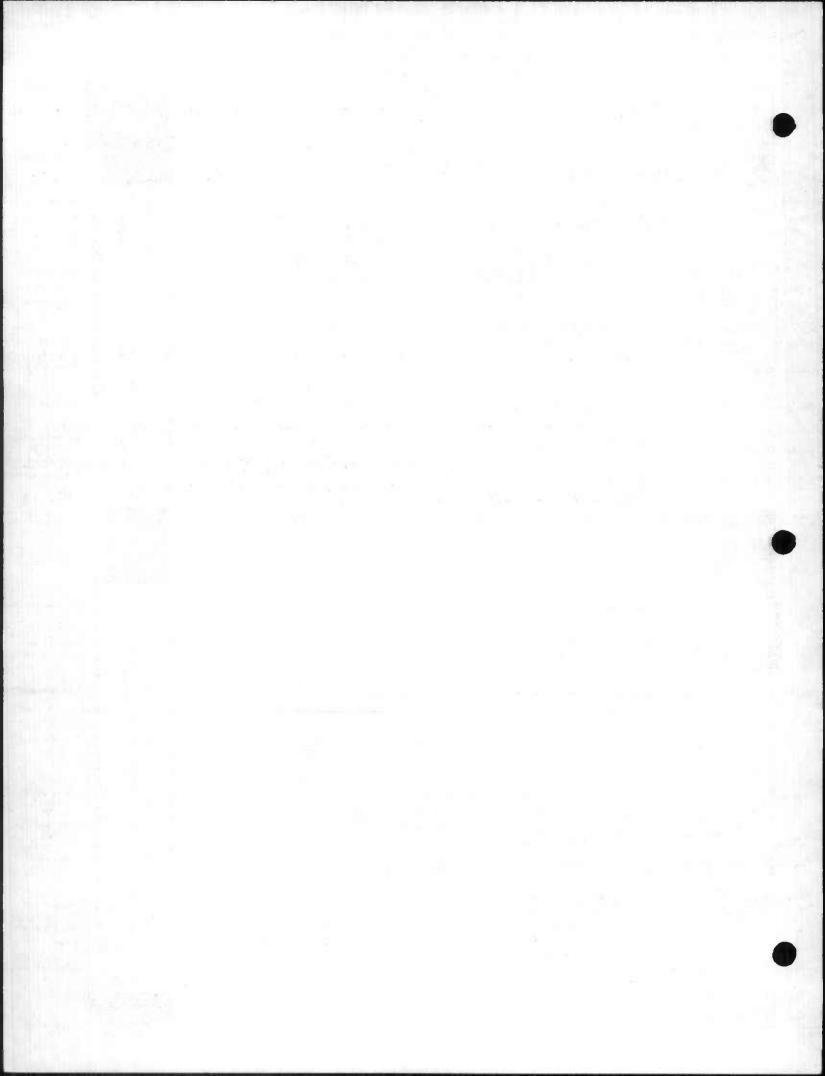
Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Month Wesley ravles March 02 2000 11:10 a.m /Medical 4e. Fecility Neme (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Deeth Examiner 7. Age (In yrs. last birthdey) If Under 1 Yeer If Under 24 Hrs. 8. Deta of Birth (Month, Dey, Year) Hospital 'orche Ster General Dorchester 5. Social Security Number Birthplece (State or Foreign Country) 6. Sex 10 M 20 F Months Deys 18-01-8182 Sept. 02, 1902 Director Maryland Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Dorchester WOOFORD 10f. Zip Code 10e. Street and Number 10g. Citizen of Whet Country? na 23a or 2 must be n Nerns 23s USA P.O. BOX 21677 by Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☑ No if Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Meritel Stetus Hygiene. ther then "natural", or item int, the Medical Examiner. 1 Never Merried 2 ☐ Merried Balltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 3 12 Widowed 4 □ Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementery/Secondery (0-12) College (1-4or 5+) Canning Industry Deasonal 60 WORKER 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Pages 1 and 2 should be I yent of Health and Mental I Jekemiah Gas 19b. Melling Address (Street end Number of Aurel Route Number, City or Town, Stete, Zip Code) 19e. Interment's Neme/Reletionship (Type, Print) Alice Item 27 is other tra Beatrice P.O. BOX 132 WOOLFORD MARYLAND 21677 -00 20b. Pleca of Disposition (Neme of cemetery, cremetery or other piece) 20e. Method of Disposition 20d. Location - City or Town, Stete important: If it any injury or o 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State Malone/st Paul Cemetery 3/8/2000 WOOLFORD, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility HENRY FUNERAL 21. Signeture of Funerei Service Licensee 23a. Perf. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, 3 Approximate shock, or heart tellure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediate Cause (Final Arterioscleropic Heart Discour disease or condition resulting in deeth) Examiner Examiner hours ASDIVATOR physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): ettending pl signed by the et Pert II. Other efanificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes en autopsy performed? page 2 s 1 Yes 2 No 1 Yes 2 No certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 27. Manner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Neturel 1 Yes 2 No 2 ☐ Accident 3 Sulcide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, term, street, fectory, office building, etc. (Specify) 4 I Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Phyelclan: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical 29c. License number 29d. Dete signed (Month, Day, Year) 47924 MI 3-3-2000 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) 300 THANWY NOMAN STREET CAMBRIDE AURORA 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture State MAR 0 6 2000 Registra



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician Maynard March 1415 Eliza /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis Hunder 24 Hrs. Hours Min. 5. Social Security Number If Linder 1 Year 8. Date of Birth (Month, Day, Year) June 18, 1914 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funerai** Months 1 M 2 XF 85 212-70-2690 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limita 'natural', or flems 23a or 28e-f show must be notified at 1 Yas 2 No Maryland Anne Arundel Director Friendship 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20758 6915 Prout Road USA Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No If Yes, Give Year or Dates: altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: Black à 3 N Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Own Home 9 Homemaker permit. Pages 1 and 2 should be fits.
Department of Health and Mental Hy important: if Nem 27 is marked offer any Injury or other to 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Smallwood Eliza Brown James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) P.O. Box 73 Friendship, MD 20758 Lucille Howard/Niece 20b. Place of Disposition (Name of cametery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from Stele 3/8/00 Carter's UMC Cemetery Friendship, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Facility Sewell Funeral Home 21. Signature of Funeral Service Licanses 1451 Dares Beach Rd. Prince Frederick, MD 20678 Sevel 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heer feilure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Acute Myocardial Infarction /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Steviosis Examiner that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or es e consequence of): P.O. Box 68760, Physician/Medical the Due to (or as a consequence of) Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yas 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to Be Completed 24a. Was an autopsy performed? completion of cause of death? page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital al or Attending Physician: The state death.

In Director: After this certificated in by the funeral director, pa 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Dete of Injury (Month, Dev Year) 28b. Tima of 28d. Describe how injury occurred 5 Pending investigation 1 Neturel 1 Tes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours after To the Funeral Dire completely filled in b Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) To the I 29d. Date signed (Month, Day, Year) 29b. Signeture end title ef certifier 29c. License number 30563 March 3, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rd Wost RNOT onensy, 76 BiEibaum 31. Date filed (Month, Day, Year) 32. Registrade Signature State

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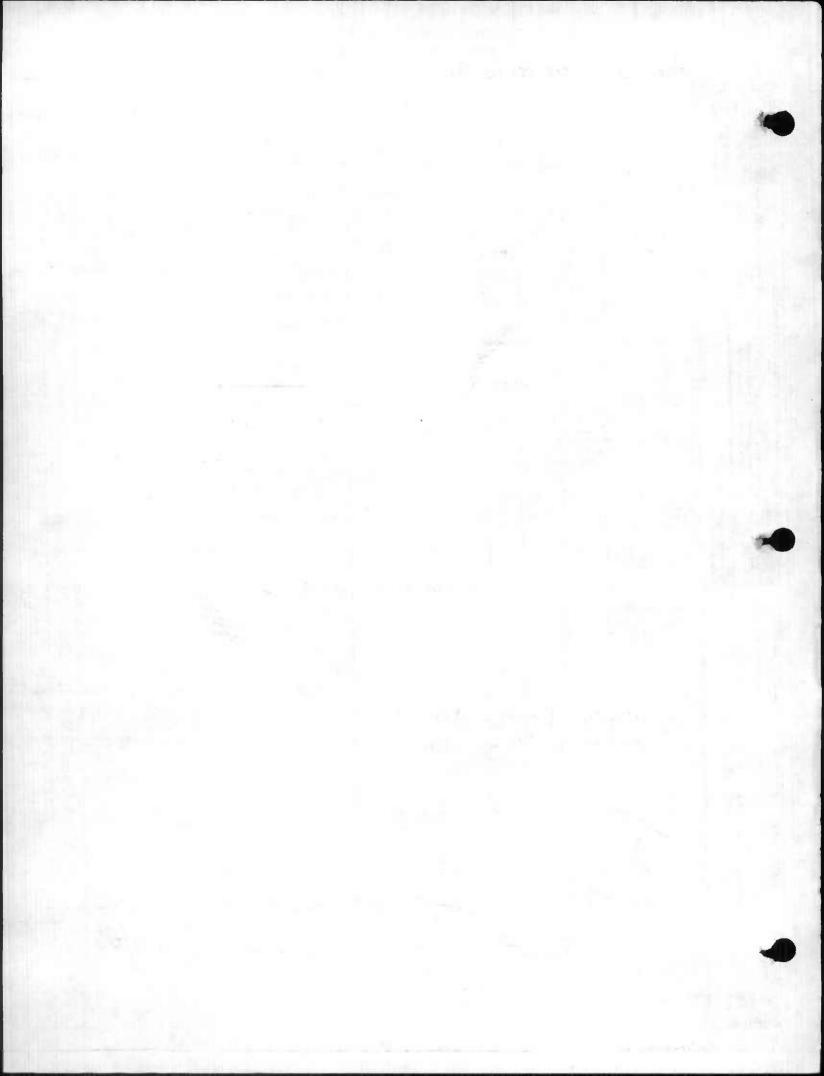
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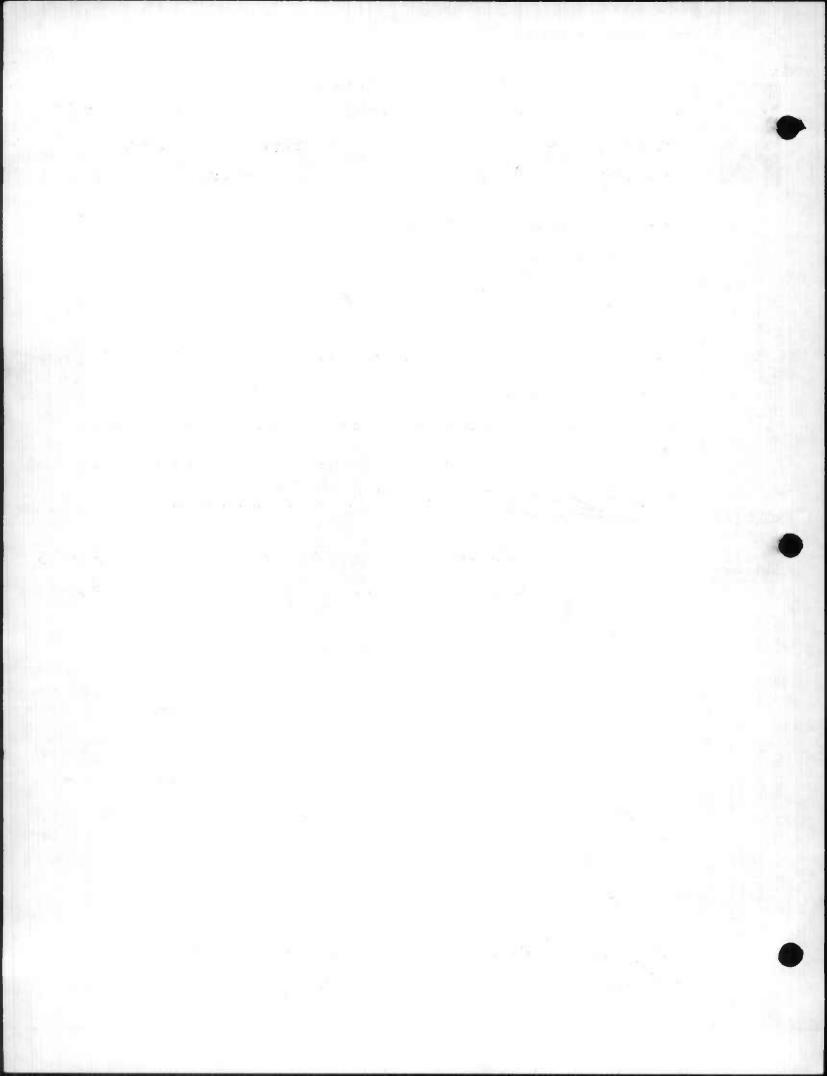
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 18. Certificate of Death 3-10-00 AS Amenaled 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Vaar **Physician** Leon R. Nice March 2000 1543 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Talbot 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 15XM 2□ F Months 90 Yrs. 139-01-7812 May 4,1909 Pennsylvania Director Usual Rasidence of Decedant 10b. County 10a. Stata 10c. City. Town or Location 10d. Inside City Limits ahow. r than "natural", or items 23s or 28s-4 shorter the Madical Examiner must be notified at Federalsburg MD Caroline 1 Yes ALYNo Director the 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 5611 American Corner Road 21632 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11 Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? filed within 72 hours after 1 ☐ Yas 2√☐ No If Yas, Giva 1 ☐ Nevar Married 2 ☐ Married altimore. Maryland 21215-0020 1 Yes 2 No Specify: Specify: White by If Yas, Giva Yaar or Datas: 3€Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Farmer Dairy 8 .. Pages 1 and 2 should be filed viment of Haath and Mental Hygle tant: If Item 27 is marked other to jury or other traumatic event, to 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Louise W. Sharpe Joseph Nice -Unknown -9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 1 6 3 2 19a. Informant's Name/Ralationship (Type, Print) 5611 American Corner Rd., Federalsburg, MD Robert R. Miller/Stepson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Department of Important: If any Injury or Cambridge Crematory 3/8/00 Cambridge, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Nama and Address of Facility
Framptom-Hawkins-Eskow Funeral Home, PA 21. Signatura of Funaral Sarvice Licensee Michael 4 skow Box 43, Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death physician /Medical DLARDIAL INFARETION Immediate Causa (Final disaasa or condition rasulting in death) Examiner 1)150056 Examiner 500 Sequentially list conditions, if any, laading to immediata causa. Entar Underlying Cause (Disease or Injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) The law requires that the death certificate be axecu Box 68760. Physician/Medical the Dua to (or as a consequence of): for use as P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown SNM Records, à 24b. Were autopsy findings available prior to completion of cause of death? director, page 2 should Be Completed 24a. Was an autopsy 45a25 1 Yes 2 No 1 Yes 2 No certificate of Vital Hospital or Attending Physician: 25. Was case refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yas 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After Division 5 Panding invastigation 1 Natural 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accidant 3 Suicide 6 Could not be detarmined 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) in by 4 Homicida pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner estated. 29a. Cartifier edical completely (Check only one) To the 29b. Signature and 9fle gl-certified 29c. License number 29d. Data signed (Month, Day, Year) 100 3962 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) Friedman, M.D. 403 Marvel Court, Easton, MD 21601 Scott D. 31. Data filed (Month, Day, Year) 32. Régistrar's Signatura State MAR - 8 2000 Registrar

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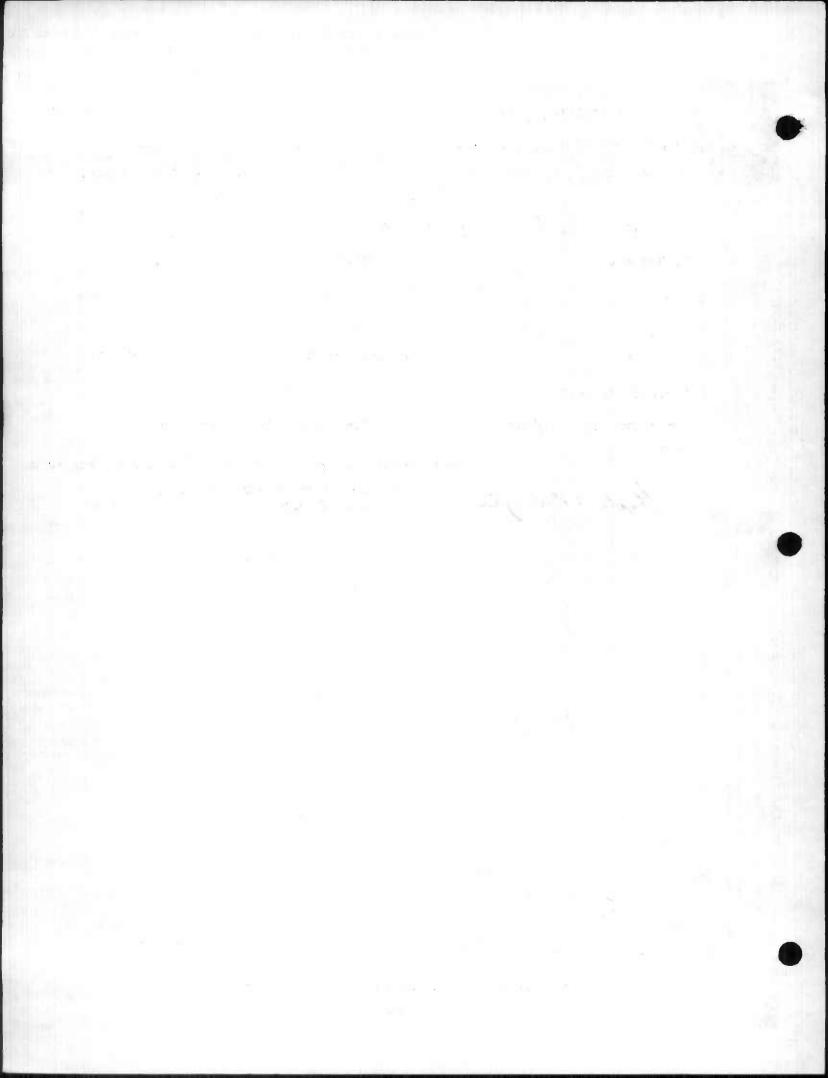


State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 2000 3 Cecilia Elizabeth Pechin 05:45 March /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner The Memorial Hospital of Easton If Under 1 Year 5. Social Security Number 7. Aga (in yrs. last birthday) Birthplace (Stata or Foraign Country) **Funeral** Months Days Hours 1□ M 200 F Yrs. 80 June 19,1919 161-03-9971 Director Pennsylvania Usual Rasidance of Dacedent death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylal Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-1 show any injury or other traumatic event, the Medical Examiner must be notified as once. Yes 2 No Director Maryland Kent Chestertown 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? Funerai PO Box 424 21620 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No If Yas, Give Year or Datas: 11. Marital Status Was Decedant of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amarican Indian. Black, White, atc. 1 ☐ Navar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yas 2 No Specify: white þ 3X Widowed 4 □ Divorcad Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collage (1-4or 5+) 11 Day Care Provider Child Care 17. Father's Nama (First, Middla, Last) 18. Mother's Neme (First, Middle, Meidan Sumama) Be 2 Fredrick S. Benditt Marie Baker 19e. Informent's Neme/Ralationship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Routa Number, City or Town, Stata, Zip Code) Chestertown, Maryland Marie Darling/ daughter PO Box 424 20b. Plece of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 X Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Holy Cross Cemetery 3-6-00 Greensboro, Maryland 21. Signature of Funaral Service Licensee 22. Nama and Addrass of Facility Fleegle & Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639 23a. Part 1. Effer the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one causa on each lina. Approximate Interval Batween Onset and Deeth **Physician** /Medical Immediata Cause (Final Dulmonary disease or condition rasulting in death) Examiner Due to (or es a consequance of): Examiner hip ractur attending physician end for use es the bunal-transit Sequentielly list conditions, if any, laading to Immadiata cause. Enter Undarlying Ceuse (Disaasa or Injury that initieted events rasulting In death) Last Dua to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 20 No 3 Probably 4 Unknown ementia by 24b. Ware autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 ☐ Yes 2 100 1 ☐ Yas 2 ☐ No certificate To the Hospital or Atlanding Physicien: within 24 hours after death.

To the Funeral Director: After this cardifict completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Othar: 4 Nursing Home 5 Rasidance 6 Othar (Specify) 1 Yes 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatiant 3 ☐ DOA 27. Menner of Death 28d. Dascribe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 5 Panding 1 Natural 1 Yes 2 No investigation 2 Accidant 3 Suicide 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 Homicide Cartifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the ceuse(s) end menner as steted.

| Medical Examinar: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, date and plece, end due to the cause(s) and mannar stated. 29a. Certifier Medical 29b. Signatura and titla of cartifiar 29c. Licensa number 29d. Data signed (Month, Day, Year) D0047534 3/00 30. Nama and addrass of parson who complated cause of death (Item 23a) (Type, Print) 920 Market Street Denton, Maryland Wafik Zaki MD 31. Date filad (Month, Day, Yaar) 32. Registrar's Signature State MAR - 7 2000 Registrar



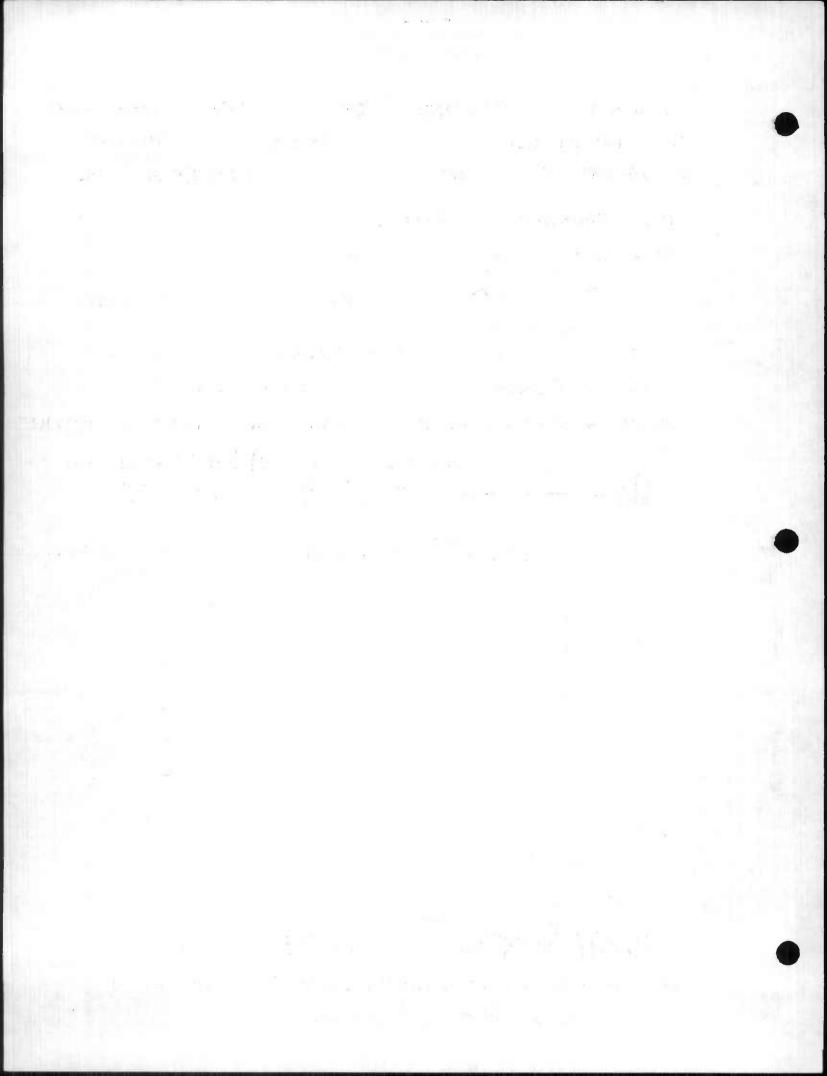
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MAYCH ROBBINS WILLIAM 4,2000 2100 /Medical 4b. City, Town, or Location of Death 4a. Facility Neme (If not institution, give street and number, 4c. County of Death Examiner Preston CAROLIN CATONINE COURT If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 9. Birthplace (State or Foreign Country)

D: 7. Age (In yrs. last birthdey) **Funeral** 15€M 2□ F 220-28-4688 Director Yrs: 65 MARCH 2, 1935 Usuai Residence of Decedent the Maryland 10a. State 10h County 10c. City, Town or Location 10d. inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumedic event, the Medical Examinar must be notified at 1 XYes 2 □ No Director Preston MD CAYOLINE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? CAROLIN 110 21655 COURT USA death Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American indian, Black, White, etc. 11. Meritel Stetus within 72 hours after 1 Never Married 2 Merried 1 ☐ Yes 2 No Baltimore, Maryland 21215-0020 Specify: p Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pemit. Peges 1 and 2 should be filed withir Department of Health and Mental Hyglene Important: If fem 27 is marked other than any injury or other traumatic avant Coilege (1-4or 5+) Elementary/Secondary (0-12) Service RETAIL 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SADIE WILLIAM ROBBINS STEWART 19a. Informant'a Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SANDRA CATOLIN ROBBINS/WIFE PRSTON, MD 21655 G. 110 COOY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Buriai 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JUNIOY ORDRY COM MOSTON 21. Signeture of Funeral Service Licensee 22. Neme and Address of Facility WILLIAM SCN FUN OV A Home FEDERASBURA MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate tnterval Between Onset and Death **Physician** ancreatie carcinoma /Medicai immediete Cause (Finai disease or condition resulting in deeth) Examiner Examiner buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of) attending physician for use es the burie Division of Vital Records, P.O. Box 68760. The iew requires that the death certificate be Physician/Medical Due to (or es a consequence of) signed by the a Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? page 2 should Completed 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending investigation t Naturai 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and piace, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and piace, and due to the cause(s) and menner stated. 29a. Certifier Medical 29b. Signature and title of certifing 29c. License number 29d. Dete signed (Month, Day, Year) MAP 316/00 30. Name end address of person who completed cause of death (item 23a) (Type, Print) David H. SmHh, M.D. 29466 Pintail Dr. Suite 5 Easton, MD 2160 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

MAR - 8 2000

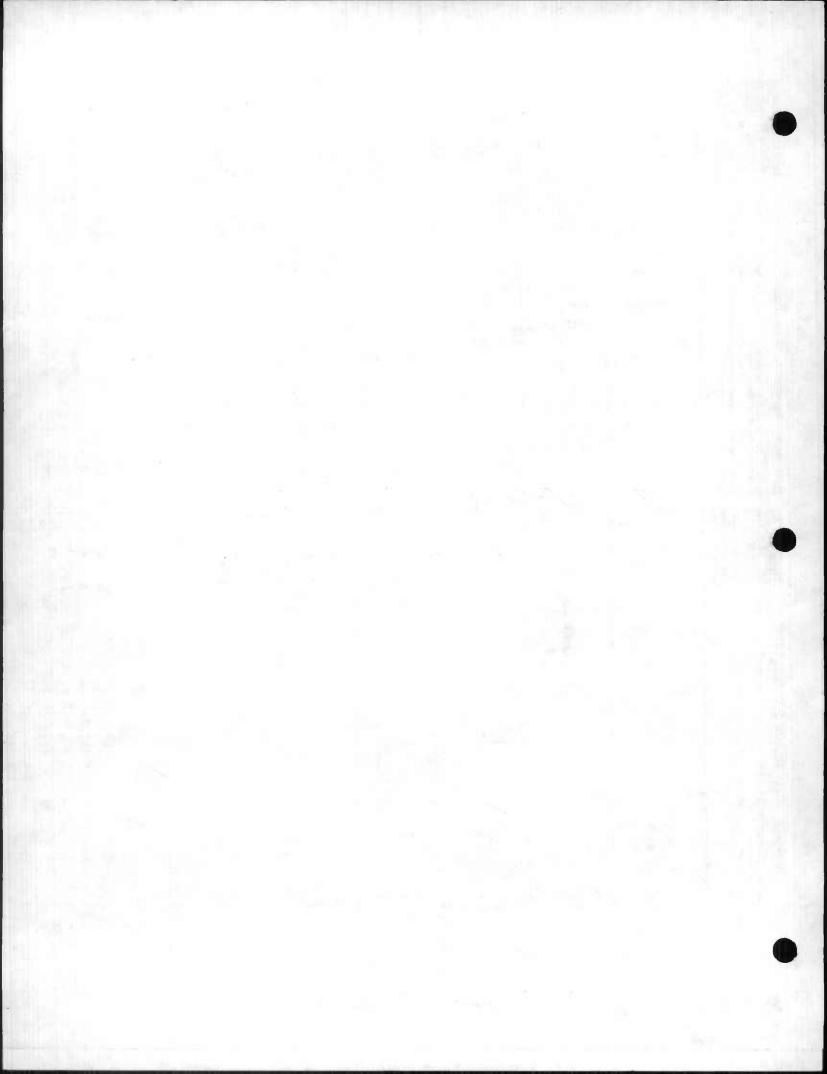


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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 0930 March 8 Howard Eugene Richard Sr 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial Hospital Easton Talbot If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1X M 2 F Days Months Yrs. Director 82 218 16 5359 July 10,1917 Maryland Usual Residence of Decede 10a. State 10b. County with the Marylan 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 No Director Maryland Caroline Goldsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b flams 23s Funeral 14755 Drapers Mill Rd 21636 USA 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ੴ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married "natural", or 1 Yes 2 No Specify: Specify: White 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygians. Hygians. Other than "n Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled wit. Department of Health and Mental Hygern important: If Hern 27 is marked other the any Injury or other treatmetic event, the J. SDRS. 11-grad mechanic manufacturing altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George Warren Richard Emma Rumbel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Richard wife 14755 Drapers Mill Rd Goldsboro, Maryland 21636 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State March 4 ☐ Donation 5 ☐ Other (Specify) Greensboro Cemetery 12,2000 Greensboro, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Fleegle & Helfenbein Funeral Home PA PO Box 160 Greensboro, Maryland 21639 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) SCHEMIC 40ARS Examiner Examiner YORRS ONAR 40325P physician and s the burlei-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of): for use as signed by the e 23b. Did tobacco usa contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yas 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? should should 24a. Was an autopsy performed? Completed hes 1 Yes 2 No 1 Yes 2 No of Vitai To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funeral Director: After this certifical completely filled in by the funeral director; 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospital: 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 123962 03.09.2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 403 Marvel Ct 32. Registrar's Signature Easton, Maryland 21601 Scott Friedman, MD MAR 100 2000 State Registrar



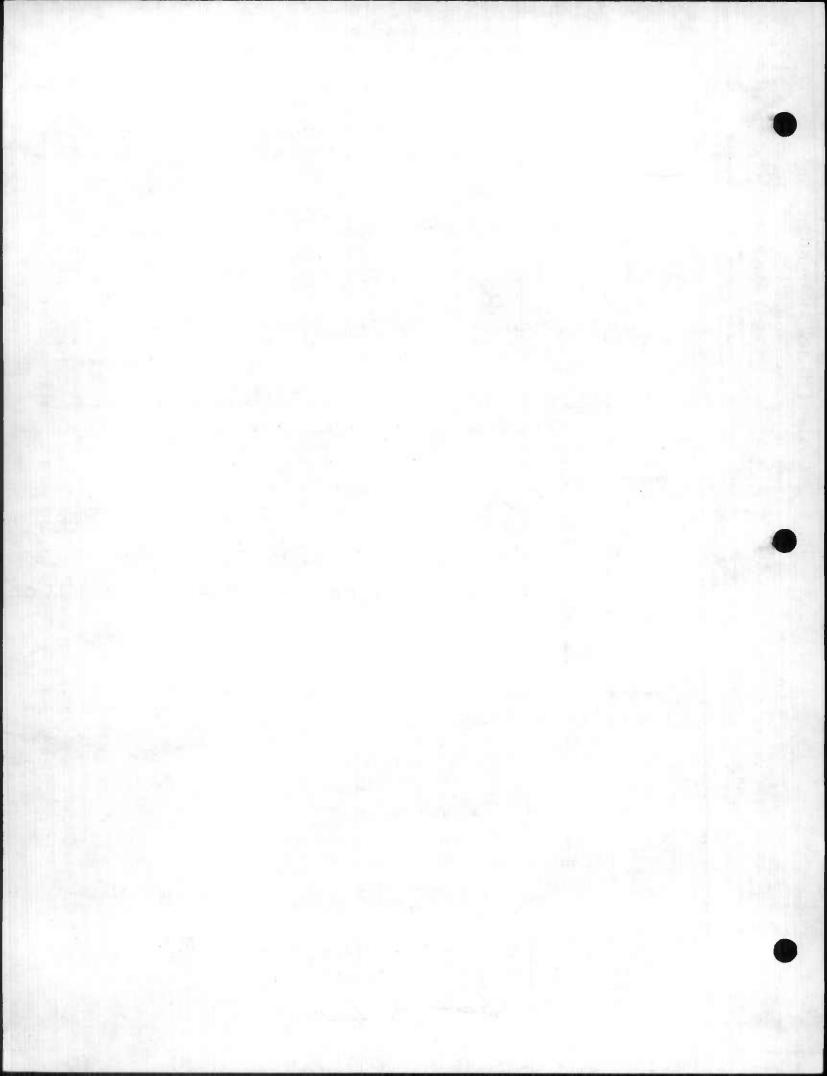
amend item 5 per fh G782 4/3/00 yg Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 0 9 0

				Ce	rtificate	of I	Death			Reg. No.) (0909				
	4	1. Decedent's Name (First, Middle,	Last)						2. Dete of De Month		Voor	3. Time of Death				
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	Examiner	4a Fecility Name (II not institution,	giva street and number)		4b. City, Town, or Lo					4c. County	of Death					
1		Memorial Hos	pital	Easton						Talb						
	Funeral	5. Sociel Security Number 218-58-0759	6. Sex 7. Age (In yr	rs. last birthday)	Months D	ear ays	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, De	th y, Year)	9. Birthpl	ace (State or Foreign try)				
н	Director	218-58-5309	97	Yrs.					Jan 4,		Germa	any				
	pu *	Usual Residence of Decedent 10a. Stete 10b. County														
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	vith the Mar t or 28e-f s be notified Director	Maryland Carol	ine	Ridgely	10f. Zip Co	vla				10g. Citizen of	What Count	10/2				
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	filed within 72 hours after death with the Maryland Hygienn. ther than "naturel", or items 23a or 28s-f show mit, the Medical Examiner must be notified as 6 Completed by Funeral Director	14259 Benedict	Lane 12. Wes Decedent Ever in	US 13	Was Deceden		1660	ioin? (Spe	cify Yes or No		A America	an Indian.				
	Her d	1 Never Merried 2 Marrie	Armed Forces?		If Yes, specify	Cuba	n, Mexica	n, Puarto	ecify Yes or No Rican, etc.)	Ble	ck, White, e					
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215	ed within 72 ho ygiene. Ar then nature A, the Widel	(Specify only highest Elementery/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	kind of work of DO NOT use r	lone d etired	during mos f)	st of worki	ng							
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la I	should be filed and Mental Hyginmarked other immatic avent, To Be Co	Joseph Schmidt					Ot	tili	a Schne	eider						
Maryland	0000	19e. Informent's Neme/Reletionshi	p (Type, Print)	19b. Meili	ing Address (S	treet	and Numb	er or Rura	I Route Numb	er, City or Town	, Stete, Zip	Code)				
	1 and 2 Health em 27 i	Sr. Mary Paul McLaughlin/guardin14259 Benedict Lane Ridgely, Maryland 21660														
ore	of He	20a. Method of Disposition 20b. Place of Disposition 20b. Place of Disposition 20c. Location - City or Town, State														
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Baitimore,	permit. Pages 1 and Department of Health Important: If hem 27 eny Injury or other to page.	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility														
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		23e. Pert1. Enter the disease, or c shock, or heert feilure. List o	omplications thet caused the de	eath. Do not en	ter the mode o	dyin	g, auch es	cardiac o	oro, Ma or respiretory a	rest,	_2163	Approximate Interval Between				
	Physician	SHOOK, OF HEER FEIGURE. LIST O	my one cause on each line.									Onset and Death				
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68760,	certificate be asscuted ving physician and use as the bunal-transit as a decical Examin	that initiated events resulting In death) Last	C. Due to	(or es e consec	quence of):						1					
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Division	offer death Director: A in by the f	3 Suicide 6 Could no determin	t be ed 28e. Plece of tnjury - At building, etc. (Spe		reet, factory, o	ffice			28f. Location (City or To		ber or Rura	l Route Number,				
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	within 7 to the comple	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mahth, Day, Year)														
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		30. Nama end address of person w	hd complete cause of death (It	em 23a) (Type,	Print)		4.1	MI	2011	200	1					
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	Registrar	MAK 1 4	4000	10	. 200	3ch	21									



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Deeth Month JOSEPH JOHN SHIMEK 2000 MARCH 1:45PM 4a. Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth DORCHESTER GENERAL HOSPITAL CAMBRIDGE DORCHESTER 7. Age (In yrs. lest birthday)
7. Syrs.

If Under 1 Year It Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
APRIL 8, 1924 6. Sex 1X M 2 ☐ F 5. Social Security Number 9. Birthplece (Stete or Foreign MARYLAND 217-16-9045 Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. inside City Limits 1 ☐ Yes 2 No MARYLAND DORCHESTER EAST NEW MARKET 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5631 CEDAR GROVE ROAD 21631 USA 12. Was Decedent Ever In U.S. Agned Forces? 1 ⊠ Yes 2 □ No 1943 – If Yes, Give Year or Detes: 1946 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1K Never Married 2□ Married 1 Yes 2 No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) SUPERVISOR FERTILIZER COMPANY 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN W. SHIMEK BARBARA NAVRATIL 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) THERESA M. SHIMEK/SISTER 5631 CEDAR GROVE ROAD, EAST NEW MARKET, MD 21631 20b. Place of Disposition (Name of cometery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Bunai 2 ☐ Cremetion 3 ☐ Removel from State 4 Donation 5 Other (Specify) 3/6/00 MD VETERANS CEMETERY BEULAH, MARYLAND 21. Signature of Funeral Service til 22. Neme end Address of Fecility ZELLER FUNERAL HOME, P. O. BOX 207, News 106 MAIN STREET, EAST NEW MARKET, MD 21631 Parf 1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, mock, or heert teilure. List one cause on each line. Approximate Intervel Between Onset and Death immediete Cause (Finel Dilated, congestive 11 months disease or condition resulting in death) Cardiomyopathy Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence ot) Due to (or as e consequence of) 23b. Did tobacco usa contributa to the causa of death? Part II. Other algnificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Pyes 2 No 3 Probably 4 Unknown pulmonary diseaple 24b. Were eutopsy tindings evellable prior to completion of ceuse ot deeth? 24e. Was en eutopsy performed? 1 ☐ Yes 2 Ø No 1 ☐ Yes 2 PNo 25. Was cese referred to medicel examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 De Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manper of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 ☐ Yes 2 ☐ No 2 Accident investigation NIX 6 Could not be determined 3 Suicide Location (Street end Number or Rural Route Number, City or Town, Stete) 4 - Homicide 29e. Certifier 🛍 Certifying Phyelcian: To the best of my knowledge, death occurred at the time, date end place, end due to the ceuse(s) end menner as steted. Defining Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and manner stated.

— Medical Examinar: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certitier 29c. License number 29d. Dete signed (Month, Dey, Year) 3.2.00 11284 maddress of person who completed cause of deeth (Item 23a) (Type, Print) Combridge MD. 21613 ARWILKE HD 400 Maryland AVE

The law requires that the death certificeta be assecuted Records, P.O. Division of Vital al or Attanding Physician: The safter death.

I Director: After this certificated in by the funerel director, pe 24 hours aft Funeral Di letaly filled in Hospital

Box 68760.

State Registrar

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Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 25s-f show the Medical Examiner must be notified at

peemit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If then 27 is marked other any injury or other traumatic event 2008.

Physician /Medical

Examiner

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Examiner

Physician/Medical

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Certification:

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31. Dete tiled (Month, Dey, Year)

MAR 0 6 2000

32. Registratr's Signature

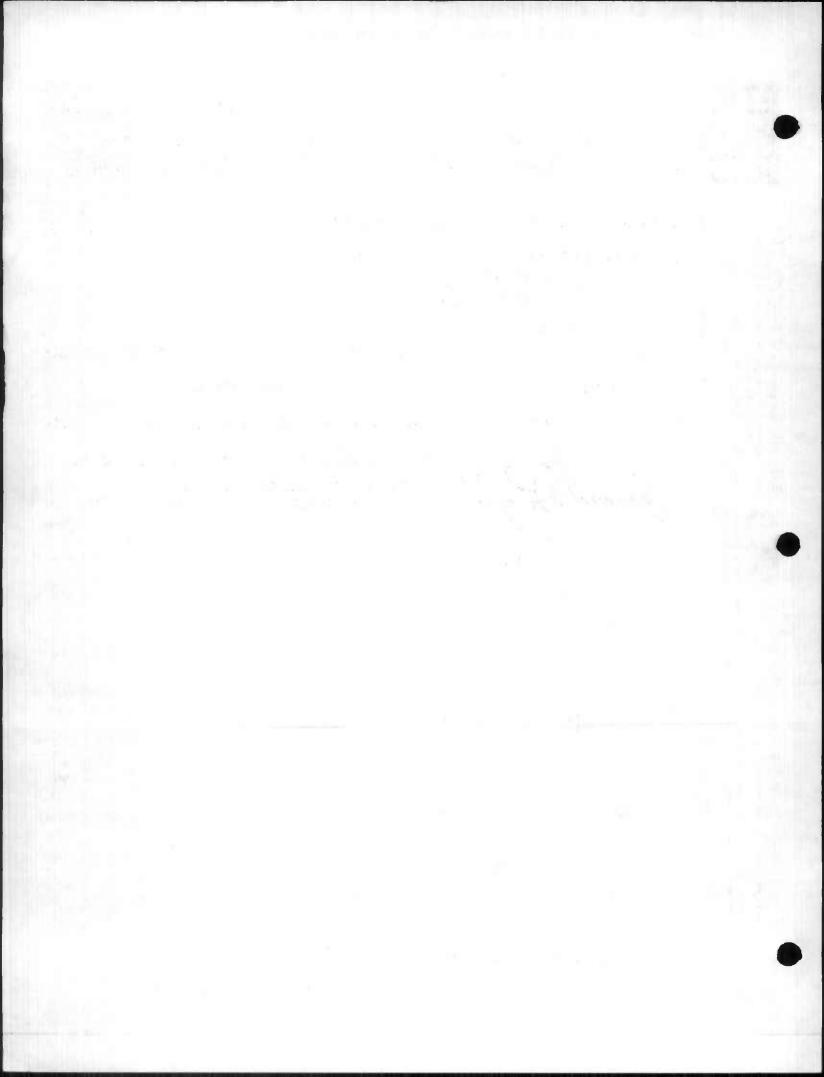
Baltimore, Maryland 21215-0020

Director

Funeral

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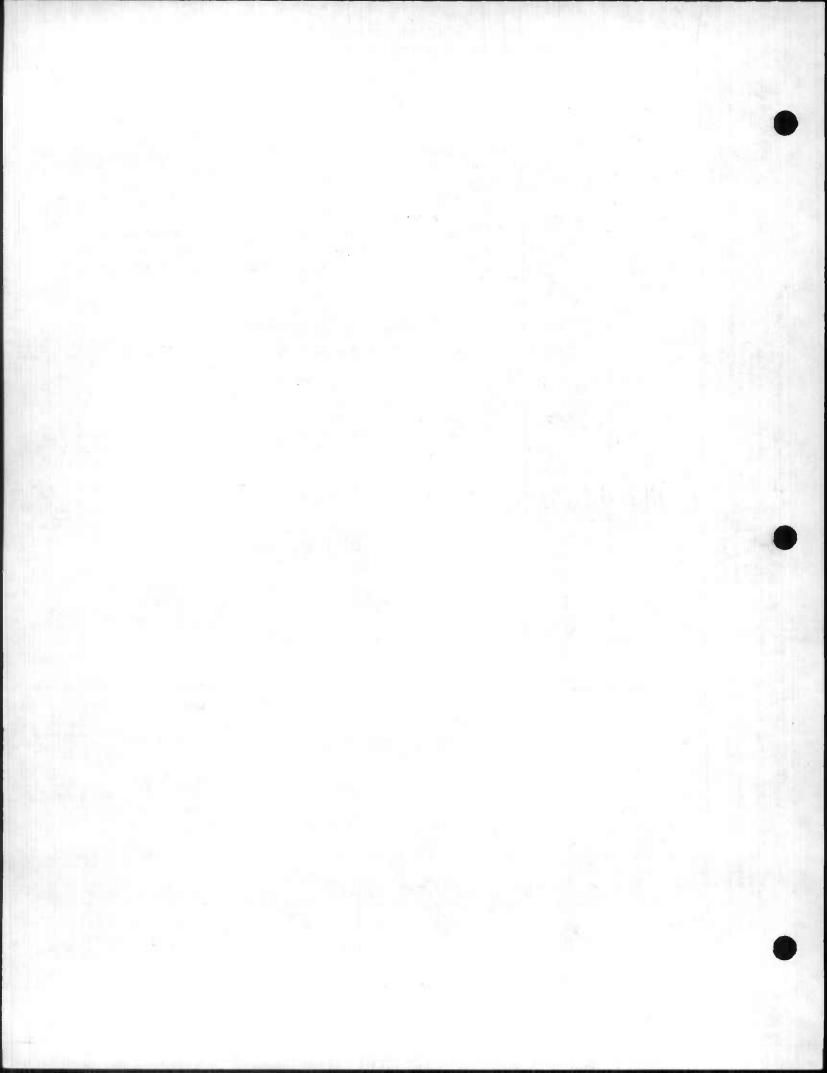
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State of Maryland / Department of Health and Mental Hygiene 00 08911

						Cert	rificate of	Death			Reg. No.		0001			
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Physician /Medical	EDWARD CHA	JR.				FEB.	24 20	000	9:25	PM						
Examiner	4a Facility Neme (If not instit	ution, gi	ve street end n	umber)			4b. City, Tox	wn, or L	ocation of Deat	4c. Count	y of Death					
	405 GLEBE R	OAD					EAS	STON		TALBOT						
Funeral	5. Social Security Number		Sex	7. Age (In yrs. last birthdey) # Under 1 Ye Months De					24 Hrs. Min.	8. Date of Bir (Month, Da	th v. Year)	9. Birth	place (State or I	Foreign		
Director	150-30-9884		IX M 2□F 59 Yrs. Months Deys					s Hours		MAR. 20, 1940 NEW JERSE						
put *	Usual Residence of Decedent 10a. Stete 10b. Co.				10c. City, Town	or Loca	ation						10d. Inside City	Limite		
72 hours after death with the Maryland natural; or items 23s or 28s4 show steal Earning must be notified at sted by Funeral Director													2 □ No			
with the Marylan a or 28s-f show be notified at Director	MD T	ALB()T		EAS	TON	10f. Zip Code				10g. Citizen of					
0	405 GLEBE R	OAD				21601					USA					
r tems 234 foer must Funeral	11. Marital Stetus	UAD	12. Was De	cedent E	ver in U.S.				nin? (Sn	ecity Yes or No						
or Items miner m	1 Never Married 2	Married	Armed F	orces?					, Puerto	Rican, etc.)	Black, White, etc.					
0	3 ☐ Widowed 4 ☐ Divor	ced	If Yes, G Year or	ive		10	□ Yes 2X N	o Specify:			Specia	y: WH.	ITE			
te de	15. Dece	dent's E	ducation	h	16a.	16a. Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)					16b, Kind of Business/Ind					
Per eld	(Specify only his Elementary/Secondery (0-1)			(1-4or 5+)	life. Do	O NOT use reti	e during most red)	oi work	ing						
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9	EDWARD CHARLE	S TI	RACY, S	R.		MARY CI										
	19e. Informent's Neme/Relet					19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code, 405 GLEBE ROAD, EASTON, MD 21601							p Code)			
	JUDITH CAREY	T		01	0											
	20e. Method of Disposition 1 Burial 2 Cremeti	Removel from	ן קיד	3-4-00	20c. Location		LE, MD									
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any injury o	21. Signeture of Euneral Sen	ice Lice	nsee	间,	650		Name and Add			& NEWN	AM FIINE	RAT. 1	HOME, P	. Δ .		
4 0	111. E. NE	w	nam		ifsp.					. EASTO			ioni, i	• 21.		
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an	Immediate Cause (Final Non-Country of Country of Countr												Onset end De	eth =		
al er	Immediate Cause (Final disease or condition resulting in deeth) e. Nousmall cell lucy carcurous											1	2 97-	,		
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edical Examiner	b.											<u> </u>				
Xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events cause indeeth) and the cause (Disease or injury that initiated events cause (Disease or injury that initiated events cause (Disease or injury that initiated events cause).															
edical	resulting in deeth) Last															
M	d.															
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hy		Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I.										1 Des 2 No 3 Probably				
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Comple												of	ompletion of cau f death?	use		
Completed										10	Yes 2 No	1	☐ Yes 2☐ N	lo		
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To	1 ☐ Yes 2 ☑ No		Hospitel: 1	Inpatien	t 2 ER/Out	petient	3LI DUA		rsing Ho	ome 5 Resi	dence 6 🗆 Ot	her (Speci	ify)			
	27. Manner of Oeath 1 ☐ Maturel 5 ☐ Per	nding	28a. Dete (Mo	e of Injury onth, Dey	Year) 28b. T	ime of njury	28c. Inj W			28d. Describe	how injury occu	rred				
by the funeral stiffication: T		stigetio	NO.					☐Yes 2☐↑	No							
Certification:	4 Homicide	emined	289. Plac	e of Injur ding, etc.	y - At home, fer (Specify)	m, stree	et, tectory, office	9		28f. Location (City or To		ber or Rur	rel Route Numbe	er,		
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edical	29a. Cartifier 1 Certi (Check only one) 2 Medi	iying Pl caf Exai	miner: On the i	e best of basis of e nner stete	xaminetion end	oeeth o	occurred et the estigetion, in my	opinion, deel	a plece, th occur	end due to the red at the time,	ceuse(s) end m dete and pieca	enner as :	to the cause(s)			
Medical Cert	29b. Signeture and title of cor	1960	ond ma	ानाचा उत्प्रति			29c. Lice	nse number			29d. Date sign	ed (Month	, Day, Year)			
5	XX	M	/								2/2	5/0	0			
	30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)											(
	DAVID H. SMI							SHITE	5. F	EASTON	MD 2160)1				
State	31. Dete filed (Month, Day, Yo		1		's Signeture	-44	A VEG	DOLLE	J, 1	LED LON,	210 ZIU	, 1				
Registrar	FEB 28 2		and the	ina	-	1	parks	,								
	1 1		61		-	1	The second second									

DHMH 16 Ray 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Tima of Deatl Month Day Year **Physician** TULLY 1616 2000 ELIZABETH 5 march /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 7. Age (In yrs. last birthday) If Under 1 Year | Months | Days If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 12/11/1909 5. Social Security Number 9. Birthplace (State or Foreign **Euneral** 1 M 2 F Hours ARIZONA 90 Director 229-44-9387 Usual Residence of Deceden 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits 28a-f show IPYes 2 No Director PRINCESS ANNE MARYLAND SOMERSET 10e. Street and Numbar 10f. Zip Code 10g. Citizen of What Country? must be 25 APT. 204 21853 11974 EDGEHILL TERRACE, usa Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Bleck, White, etc. 1 Yes 2/2/No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: 8 ď 3 Widowed 4 □ Divorced WHITE 'natural'. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 12 LIBRARIAN FEDERAL GOVERNMENT 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) ses 1 and 2 should be fit of Health and Mental H I flem 27 is marked off Be MARIE BEAN DONALD M. RAIT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12271 SOMERSET AVE., PRINCESS ANNE, MD. 21853 JOHN O. TULLY/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages nent of P 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removat from State Department of Important: If any injury or ä SALISBURY CREMATORY 3/7/00 SALISBURY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses HINMAN FUNERAL HOME 11673 SOMERSET AVE., PRINCESS ANNE, MD. 21853 / M00295 MARCA Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervai Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical the Due to (or as a consequence of) USB BS Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dtd tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 YUnknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate or Attending Physician: funeral director, Be 25. Was case reterred to medicat examiner? 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. tnjury at Work? After 5 Pending investigation 1 Devatural s after death. 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide To the Hospital c within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner es stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

229-44-9387

Elizabeth

Vital

Division of

Maryland

Baltimore,

31. Date filed (Month, Day, Year)

of person who comp

30. Name and address

32. Registrar's Signature

ed cause of death (Item 23a) (Type, Print)

STREET, SALISBURY IN

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Please Type or Print in Biack indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician FEBRUARY 23,2000 6:15 PM HENRY HARRIS THOMAS /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WALDORF CHARLES 121800 GILLESPIE CIRCLE 8. Data of Birth (Month, Day, Year) Aug 12, 1927 If Under 1 Yaar If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days Months Hours 579 32 3482 1⊠M 2□ F 72 Yrs. Wash., Director Usual Residence of Decedent death with the Maryland 10a State 10b. Counts 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itema 23e or 28e-f ahow the Wednel Examiner must be notified at Waldorf 1 ☐ Yes 2 No Maryland Charles Directo 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 12180 Gillespie Circle 20601 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 11 Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yas 2 ☑ No Specify: Specify: p 3 ☐ Widowed 4 ☑Divorced white Year or Dates Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filled within: Department of Heelth and Mental Hyglens. Important: If item 27 is marked other than *e eny injury or other treumatic avent, this held place. Elementary/Secondary (0-12) College (1-4or 5+) laborer construction 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 8 unknown unknown ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane M. Poole / daughter 56 Patuxent Mobile Estates, Lothian, MD 20711 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Method of Disposition Data 20c. Location - City or Town, Stata 1 Burial 2 Cremation 3 Removal from Stata
4 Donation 5 Other (Specify) Metropolitan Crematory 3-1-00 Alex., 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Rausch Funeral Home, P.A., Owings, MD 20736 com 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Terminal Pancreatic Cancer Examiner Due to (or as a consequence of): Examine physician and the burial-transit be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760 an/Medical Dua to (or as a consequence of): attending p 8 Physici signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed Deed certificate hes 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was pase referred to medical exaptiner? å 26. Place of Daath (Check only one) Hospital: Other: 4 Nursing Homa 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) this funeral To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director; After thi completely filled in by the funeral 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Tima of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Routs Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Caritying Physician: To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number lacouri m,) 2-25-00 D-50883 25500 PT. LOOKOUT ROAD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10

DHMH 16 Rev 6/95

State

Registrar

AHTA M.

DEPT.

MARYS HOSPITAL

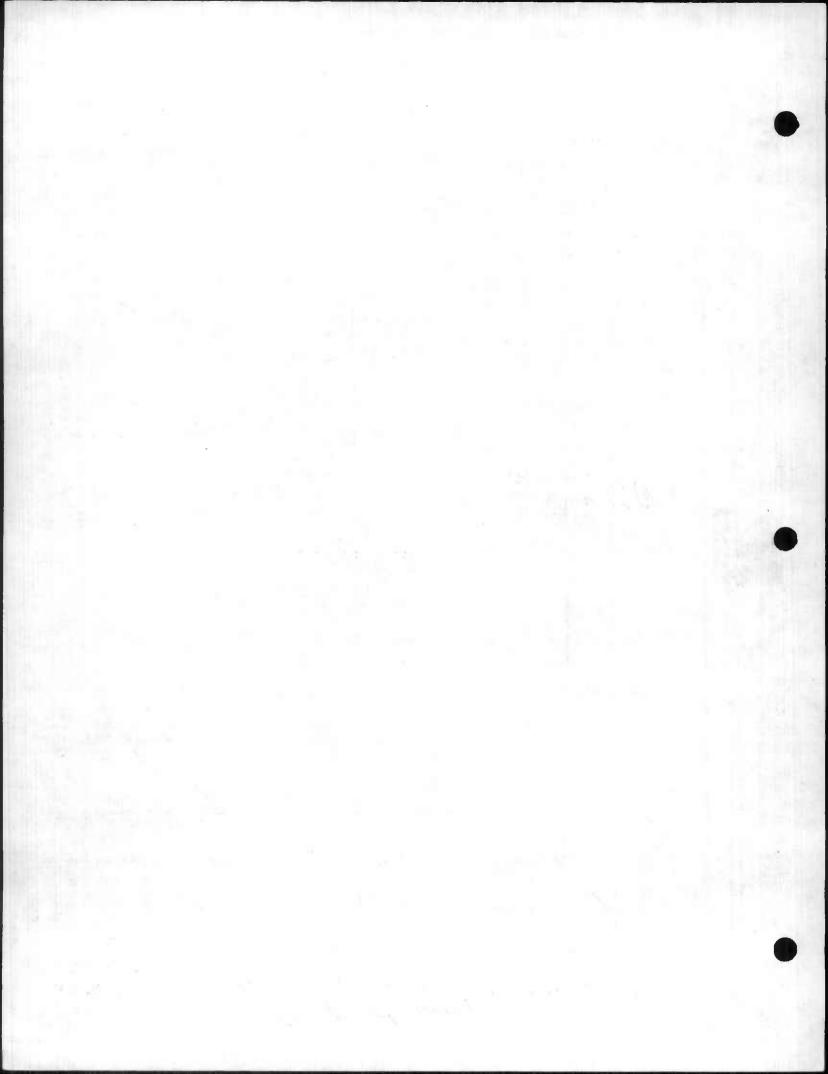
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0 2 2000

32. Registrar's Signatura

TAGOURI M.D.

OF PATHOLOGY LEONARDTOWN MD. 20650



State of Maryland / Department of Health and Mental Hygiene 08914 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Deeth Day Yesi **Physician** Month NEWTON **JACOB** WILDASIN 4b. City, Town, or Location of Death 1 2000 4c. County of Death 8:25 PM /Medical 4e Facility Nema (If not institution, give street and number) Examiner Genesis ElderCare
5 Social Security Number 6. Sex Easton Talbot The Pines If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) SEPT.12,1909 9. Birthplaca (Stata or Foreign **Funeral** Days Hours XXM 2DF 90 Months PENNSYLVANIA 176-05-0882 Director Usual Rasidanca of Decedant 10a Stata 10b. County 10d. Insida City Limits 10c. City. Town or Location X□ Yes 2□ No Director 288-1 TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 640 MECKLENBURG AVENUE, APT. 224 Berrs 23a 21601 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2000No If Yas, Giva 14. Raca - Amarican Indian. Bleck, Whita, atc 1 Nevar Married 2 Married Baltimore, Maryland 21215-0020 "natural", or 1 Yas 2 No Specify: WHITE Specify à 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Etamantary/Secondary (0-12) Collega (1-4or 5+) PIPE FITTER FLOOR COVERING 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) Be and Mental MURDITH WILDASIN MARY C. MONATH 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) mportant: If item 27 is 508 DECATUR PLACE, EASTON, MD 21601 N. EDWARD WILDASIN/ SON 20b. Place of Disposition (Nama of camatary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 8 1 ☑ Burlel 2 ☐ Cremetion 3 ☐ Ramoval from Stata MEADOW BRANCH CEMETERY 4 ☐ Donation 5 ☐ Othar (Specify) 3-4-00 WESTMINSTER, MD 21. Signatura of Funaral Sarvice Licansaa 22. Nama and Addrass of Facility F.S.P. FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME 23a. Part1. Enter the disaesa, or complications that caused tha death. Do not anter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Intervat Batween Onset and Death **Physician** /Medical Immedieta Causa (Final CHRONIC PNEUMONIA

Dua to (or as a consequence of): WEEKS disaasa or condition rasulting in daath) Examiner Examiner OBSTRUCTIVE DYLMONALV tha death certificate be axecuted Sequentielly list conditions, if eny, laading to immadiata causa. Entar Underlying Causa (Disaase or Injury that initiated evants resulting in death) Last L FIBRILLATION
Due to (or as a consequence of): Box 68760, Physician/Medical the INSUFFICIENC Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.0. 3 Probably 4 ☐ Unknown 1 Yea 2 No ANEMIA Records, Completed by 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? CHAGNIC PLEURAL EFFUSION 1 Yas 2 No 1 Yas 2 No Division of Vital or Attending Physician: Be 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only ona) 21 No Other: 4 Nursing Homa 5 ☐ Rasidence 6 ☐ Other (Specify) 1 Yas Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Panding death. 1 ☐ Yas 2 ☐ No investigation n 24 hours after death e Funeral Director: / pletely filled in by the f 2 Accident 6 Could not be datarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Cartifiar Medical To the Hosp within 24 hor To the Fune completely fi (Check only one) 29c. Licensa number 29d. Data signed (Month, Day, Year) 29b. Signetura and title of MAKAS 30. Nema and addrass of person who do inpleted causa of death (Item 23a) (Type, Print) 2/60/ MAKAS 508 IDECUILD AVE. 31. Data fited (Month, Day, Year) 32. Registrar's Signatura State

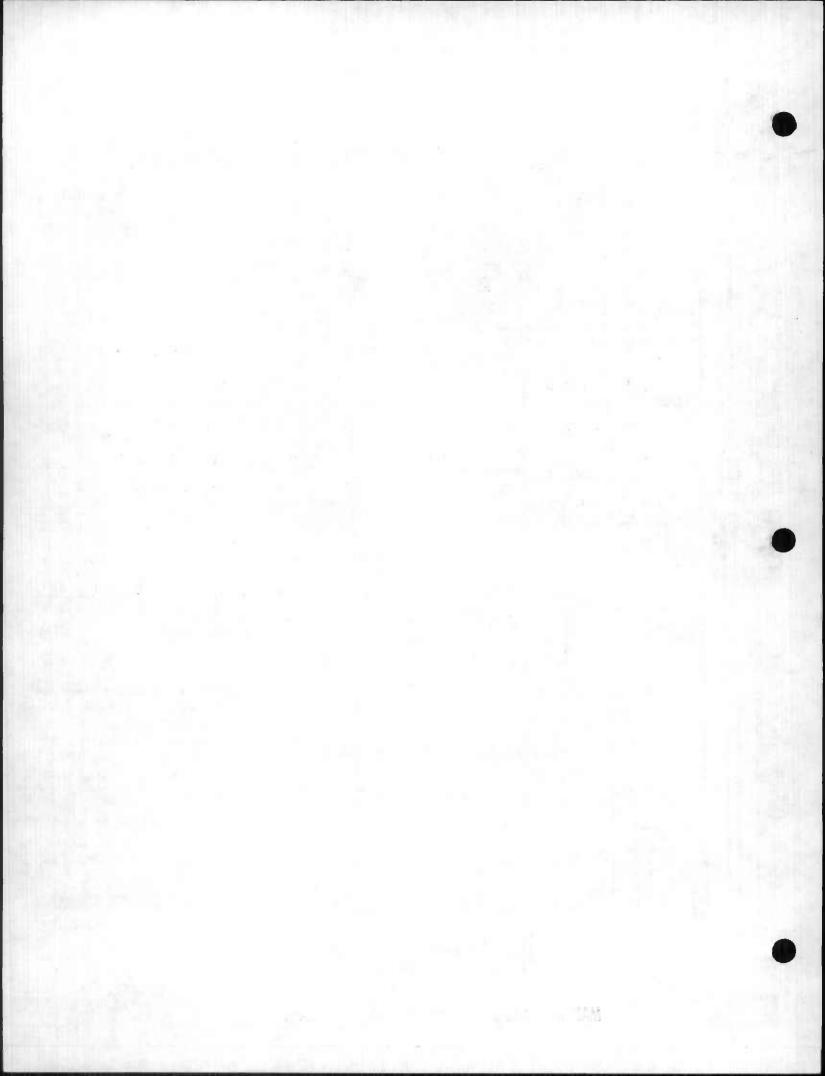
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Registrar

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2000

Newton Wildasin



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year JOHN MARTIN WEGENER 28, Feb 2000 1225 4e Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Memorial Hospital Easton Talbot If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. lest birthdey) 9. Birthplace (State or Foreign Deys 1€ M 2□ F MISSOURI Yrs. 487-26-3175 Usual Rasidence of Dacedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1X Yas 2□No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 29373 HICKORY RIDGE ROAD 21601 USA 12. Was Decedent Ever in U,S. Armed Forces? 1. Dives 2 | No If Yes, Give Year or Dates: 1943-1946 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced WHITE 16s. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 SALESMAN REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) HENRY WEGENER MARIE ROTTER 19a. informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARIANNE WEGENER / WIFE 29373 HICKORY RIDGE ROAD, EASTON, MD 21601 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date **Burial 2 Cremetion 3 Removal from State JOSEPH CEMETERY 3-2-00 CORDOVA, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. Estrows/1' 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest shock, or heart failure. List only one cause on each line. Approximata Intervai Between Onsat and Death Immediate Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immadiate cause. Entar Underlying Cause (Disease or injury that initiated avents resulting in death) Last Due to (or as e consequenca ol): Due to (or as a consequence of):

Physician /Medical Examiner

certificate be axecuted physician and is the burial-tran

P.O. Box 68760,

Records,

Division of Vitai

Hospital or Attanding 24 hours after death. Director: , d in by the

To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by

Physician

/Medical

Examiner

Director

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'natural', or itsms 23s or 28s-f shor

John Wagener

Maryland 21215-0020

Baltimore,

Examiner Physician/Medical þ Be Completed Medical Certification: To

signed by the aid be detached

Pert	it. Other significant conditions of	contributing to death but not re	sulting in the underlying	cause given in Part I.	23b. Did tobacco use co 1 ☐ Yee 2 ☐ No	ntribute to the cause of death? 3 Probably 4 Tunknown
					24a. Wes an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
	Was case referred to medical			26. Place of De	eath (Check only ona)	
	examinar? 1 ☐ Yas 2x0 No	Hospital:	XER/Outpatient 3□ □	OA Other: 4 Nursing	Homa 5 ☐ Residence 6 ☐ Ott	ner (Specify)
	Manner of Death SNaturat 5 Panding Company Panding Investigation		28b. Tima of Injury	28c. Injury at Work? 1 Yes 2 No	28d. Describe how Injury occur	red
	3 Suicide 6 Could not b		home, larm, street, facto	ry, office	281. Location (Street end Numb City or Town, Stete)	ber or Rural Route Number,

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signeture end title of certifier

Tow 31. Date filed (Month, Day, Year) MAR 0 2

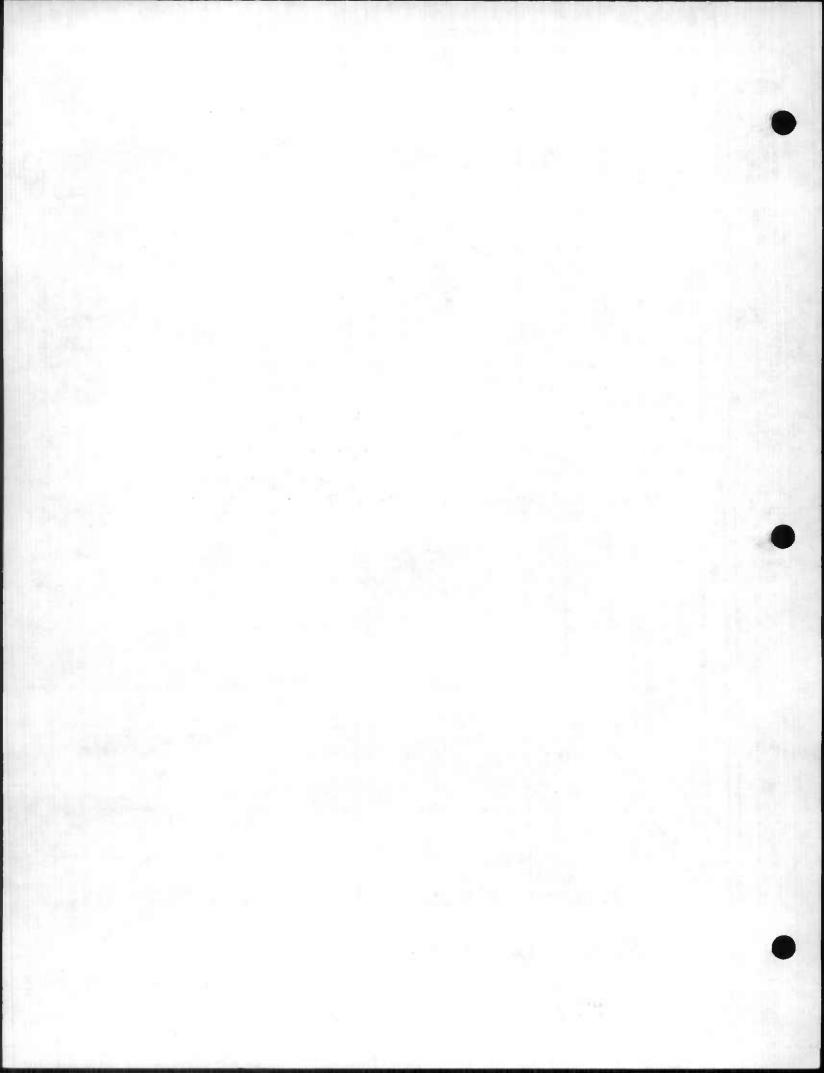
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DHMH 16 Rev 6/95

dress of person who completed cause of death (Itam 23a) (Type, Print)

2000

32. Registrant Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 0 8 9 1 6

			Cen	tificate of	Death	F	leg. No.		
	1. Decedent's Nama (First, Middle, Last)				2. Date of Dea Month	th Day	Yaar	3. Time of Dea
Physician (Market)	Esther G.	Wilson				Fe4		200	528 500
/Medical Examiner	4e Facility Name (If not institution, give	street end number)			4b. City, Town, or	Location of Death	4c. County	of Deeth	
	Chesapeake Wo	ods Center			Cambri	dae	Dor	ches	ter
Funeral	5. Social Sacurity Number 6. Sa		last birthdey)	If Under 1 Year	If Under 24 Hrs				ce (State or For
Director	170-50-2125 Usual Residence of Decedent	□M 2X0XF 96	Yrs.	Months Days	Hours Min.	OCT.18,			YLVANIA
B 11	10a. State 10b. County	10c. Cit	y, Town or Loc	ation				100	d. Insida City Li
or 28e-f sh be notified.	MD TALBO	T		EASTO	N				1 XYes 2 □
	10e. Street and Number 243 BROOKWOOD			10f. Zip Code	601		10g. Citizen of W USA		y?
E 2	11. Marital Status	12. Was Decedent Ever In U Armed Forcas?	,S. 13. W	as Decedent of	Hispanic Origin? (S ben, Mexican, Puer	pecify Yes or No-	14. Race	e - America	
Lamine Examine by Fur	1 Never Married 2 Merried 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Detas:		Yes 2 No		o nican, etc.;	Specify	k, White, et WH	ITE
"natura dical E	15. Decedent's Edu (Specify only highest grad	cation	16e. Decede	ent's Usual Occu	petion	rkina	16b. Kind of Bu	isiness/Indu	istry
t, the Med Comple	Elementary/Secondary (0-12)	Collega (1-4or 5+)			during most of wo	Airiy	orni v	01/17	
A 0	11	-0-	HOUSE	WIFE		45° 4 84° 44°	OWN H		
ne son	17. Fether's Name (First, Middle, Last)				18. Mother's Na	na (First, Middla,		(a)	
To mark	"UNKNOWN"	CHICAGO CONTRACTOR CON				"UNKNO		#110 to 1977	
Tall I	19a. Informant's Name/Raietionship (T)				t and Number or Ri			Stete, Zip C	Code)
Par 2	FRANCIS K. HARVEY			****	, EASTON,			01.	- Du
nt: if its	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ f 4 ☐ Donetion 5 ☐ Other (Specify)	Removal from State	cemetary, crem	ition (Nema of etory or other plo LL CEME	TERY	3-2-00	EASTON,		
sician edical miner Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Ceuse (Final disease or condition resulting in deeth)	Septic Dua to (c	h. Do not ente	O S. HA r the mode of dy o c k	HELFENBEI RRISON ST ing, such as cardie	., EASTO	N, MD 2	1601	OME, P. Approximata Interval Betwee Onset and Dea
d by the attending physician and letached for use as the buriet-transit Physician/Medical Examir	Sequentially list conditions, if eny, leeding to immadiata causa. Entar Underlying Cause (Disaase or injury that initiated events rasulting in death) Last	Due to (o	or as a consequ	ence of):					
the at hed for ysic	Part II. Other eignificant conditions co	ntributing to death but not res	ulting In the un	derlying cause g	iven In Part I.	23b. Dld t	obacco use cor	ntribute to	the cause of d
igned by the abe detached by Physic	Sevile Da	emertia				101	108 2/2KNa	3 Probe	ably 4 Uni
should should	Servile De Hypertens	sion					an eutopsy med?	avai	re autopsy findi ilable prior to apletion of caus eath?
page 2						101	es 20 No	10	Yes 20 No
rector, pay	25. Was case raferred to medical				26. Place of De	ath (Check only o	ne)	1	
I direct	axaminer?	Hospitel:	ER/Outpatient	3 DOA		fome 5□Resid		ar (Specify)	
= m	27. Manner of Deeth 1 Naturel 5 Pending	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju		T	ow Injury occurr		
To the Funeral Director: Affact completely filled in by the funeral Medical Certification:	2 Accidant investigetion 3 Suicide 6 Could not be 4 Homicide datamined	28e. Place of Injury - At h building, etc. (Specif	oma, farm, stra y)			28f. Location (S City or Ton	Street and Numb n, Steta)	er or Rural	Route Number,
pletely fille edical C	29a. Certifier Certifying Phy (Check only one)	sician: To the best of my kno ner: On the basis of axamina end manner stated.	wiedga, death tion end/or invi	occurred at tha tastigation, in my	tima, data and place opinion, daeth occu	e, and dua to the curred at the time,	ceuse(s) and me data and place,	enner es sta and dua to	nted. the cause(s)
ompi Me	29b. Signature end title of cartifier		100		nse number		29d. Date signed		
- 0	Mette	Telen us		D:	2638 Ws MX	8	Feb a	29,	2000
	30. Neme and address of person who co	emplated cause of daeth (Item	n 23a) (Type, F	Print) 2 CO//1	Ws Ne	Hur	lock 1	MED 6	2/64
State	31. Date filed (Month, Dev. Year)	32. Registrar's Signa	ature	4	10011				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Deta of Death Month WINDSOR EDGAR E. 8:17Am 4b. City, Town, or Location of Dagth a74a. Facility Neme (If not institution, giva street and number) 4c. County of Death Manokin Manor Nursing Home Princess Anne Somerset 5. Social Security Number If Undar 1 Year If Under 24 Hrs. Birthpleca (Steta or Foreign Country) Maryland 7. Age (In yrs. lest birthday) 1 M 2 □ F Days 220-03-3857 90 Yrs. Usuel Residance of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Somerset Crisfield. 10a. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 26418 Old State Road 21817 USA 12. Wes Decedent Ever in U,S. Armed Forcas? Was Decedent of Hispenic Orlgin? (Specify Yas or No-If Yes, specify Cuban, Maxican, Puarto Rican, etc.) Race - American Indien, Bleck, White, etc. 1 M Yes 2 □ Noworld If Yas, Giva Year or Detes: War II 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 □ Divorcad 15. Decadent's Education (Spacify only highest grede com 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry rede completed) Elamantary/Secondary (0-12) Collage (1-4or 5+) Cutlery Mfg. Production 11 (Graduate) 0 17. Father's Nema (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnema) Ellis Windsor Ethel Dise 19e. Informent's Neme/Retationship (Type, Print) 19b. Mailing Address (Streat end Number or Rural Route Number, City or Town, Steta, Zip Code) 201 Gandy Lane - Crisfield, MD Sandra Y. Windsor (niece) 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, crematory or other plece) 20c. Location - City or Town, Stete Data 1 Burlel 2 ☐ Cremation 3 ☐ Removel from Stata 4 Donetion 5 Other (Specify) Sunnyridge Memorial Park 3/1/00 Crisfield. MD 21. Signeture of Juneral Sarvice Licenses 22. Name end Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD Robert H. Bradshaw 21817 23a. Pert1. Enter the disaasa, or complications that caused the deeth. Do not entar tha mode of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only one causa on each line. Approximata Intervel Between Onset end Deeth Immediate Ceusa (Finel diseasa or condition resulting In daath) Sequantially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Diseesa or Injury that initioted events rasulting in deeth) Lest Due to (or es e consequence of): Due to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed? 24b. Were eutopsy findings evailable prior to complation of cause of death? 1 Yes 2 No 1 ☐ Yes 2 No 25. Wes case refarred to medical axeminer? 26. Place of Death (Check only one) Other: 418 Nursing Home 5 Residance 8 Other (Specify)

Physiclan /Medical Examiner The law requires that the death certificete be axecuted end

physiclan

signed by

After this certificate has

after deeth.

To the Hospital within 24 hours a To the Funeral Completaly filled

in by the funaral

Box 68760,

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Physician

/Medical

Examiner

Funeral

Director

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nd Mental Hygiena. marked other than

permit. Peges 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic even-

Director

Funeral

Completed by

Be

traumatic event, the Medical Examiner naut be notified at

filed within 72 hours after death with the Maryland

Examiner Physician/Medical Completed by Be 2 Certification:

1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Mennar of Deeth 28e. Dete of injury (Month, Dey Year) 28b. Time of 5 Pending investigation 1 Naturei 2 Accident

28c. Injury et Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

6 Could not be 28e. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a, Certifian

3 Suicide

4 Homicida

1 Certifying Physicien: To the bast of my knowledge, death occurred et the time, date end plece, end due to the ceusa(s) and mannar as stated. 2 Medical Examiner: On the basis of axamination end/or invastigation, in my opinion, daeth occurred et the time, date end piece, and dua to the cause(s) and manner steted.

290. Signature and title of cartifier regario M.

29c. License number

29d. Dete signed (Month, Dey, Year)

M. Nema end addrass of person who completed causa of daath (Itam 23a) (Type, Print)

GREGORIO M. BELLOSO, M.D.; 5302 CHINABERRY DR.; SALISBURY, MD 2180) 31. Dete filed (Month, Day, Yaar) 32. Registrer's Signeture

State Registrar

Medical



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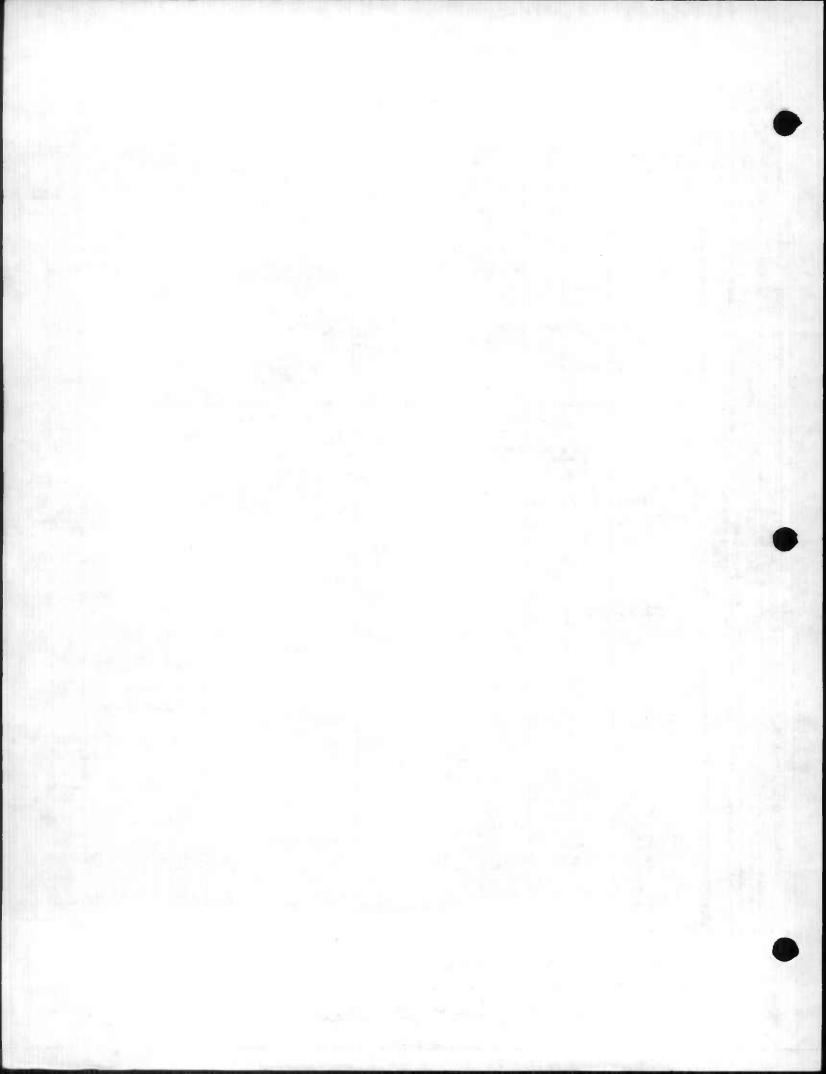
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death Day Month **Physician** ESTHER ELIZABETH WHEATLEY March 4, 2000 2129 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** The Memorial Hospital Easton | H Under 1 Year | H Under 24 Hrs. | 8. Data of Birth | Days | Hours | Min. | Hours | Min. | Feb. 17, 1935 | Maryland Talbot 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** 10 M 20XF 65 214-30-8324 Director Usual Rasidanca of Dacadant 10a Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits ahos MD Caroline Federalsburg 1 Yes 2 No Director 28s-f 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? b 306 East Central Avenue 21632 United States Berns 23a Funeral 12. Was Decedent Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, Whita, etc. 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married "natural", or I Baltimore, Maryland 21215-0020 1 ☐ Yes 2)(☐)(No Specify: White Specify: p 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) Esther Wheatley Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Elementary School Cafeteria 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Nama (First, Middle, Last) Be 1 and 2 should be and Mental Earl Dukes Agnes Douglas 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code), 2 1 6 3 2 19a. Informant's Name/Raiationship (Type, Print) 306 E. Central Ave., Federalsburg, MD Hobart Wheatley/Spouse Important: If Item 27 any injury or other tr 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stata 8 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) 3/9/00 Federalsburg, MD Hill Crest Cemetery 22. Nama and Address of Facility Framptom-Hawkins-Eskow Funeral Home, PA 21. Signatura of Funaral Sarvice Licensee Esteni PO Box 43, Federalsburg, MD 21632 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical Years Examiner Due to (or as a consequence of) Examiner physician and the buriel-trensit The lew requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Causa (Disaase or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of): Box 68760. Physician/Medical Dua to (or as a consequence of): USB Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. ewopath 1 □ Yaa 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 s 1 ☐ Yas 2 DeNo 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Xinpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To this funeral 27, Mannar of Death 28d. Describe how injury occurred 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After 5 Pending invastigation 1 Naturai 1 ☐ Yes 2 ☐ No deeth. 24 hours after deeth Funeral Director: A 2 Accident 6 Could not be detarmined 3 Suicida Location (Street and Number or Rural Routs Number, City or Town, State) 28e. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida 24 hours 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated. 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. (Check only one) To the F within 2 29b. Signature ageritle of coglille 29c. License number 29d. Data signed (Month, Day, Year) 00 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print) Oliver, M.D. 503 Dutchman; s Lane, Easton, MD 21601 David Greg 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State Depera MAR - 8 2000 Registrar

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ORLAND	OY C	DUNG	State of	Marylan		ertifica			ind M	ental Hy	Reg. No.	1 08	919
Phys /Me	ician dical	Decedent's Name (First, Middle, Last Orlando	1)		You	ng		4		2. Date of Dea Month MARCH	Day	Year	Time of Death 0021 AM
) Exan		4a Facility Name (If not institution, give ROUTE#2	street and numi	ber)				b. City, Tow SOLO		cation of Death		of Death VERT	
Funera Directo		5. Social Security Number 218-84-4671 6. Se	X 7	Age (In yes 24	last birthda; Yrs.	// If Unde Months	r 1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Dete of Birth (Month, Da Feb. 2	, Year) 7, 1976	9. Birthplace Country! Maryl	(State or Foreign
pu »		Usual Residence of Decedent 10s. State 10s. County		100 00	y, Town or I	anation						104 5	nside City Limits
Aaryte	5			100.00		well							Yas 2 No
100 H	Director	Maryland Calver	L		טט		p Code				10g. Citizen of V	What Country?	
h with		13625 Dowell Roa	ıd				206	529			USA	A	
72 hours effer deeth with the Maryland natural; or frams 23e or 28e-f show size Example must be notified at	by Funeral	11. Merital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	12. Wes Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? No	,S. 13	Was Dece If Yes, spi		ispanic Orig in, Mexican, Specify:	gin? (Spe , Puerto I	cify Yes or No Rican, etc.)	Blec	e · American Inck, White, etc.	dian,
within	Completed	15. Decedent's Edi (Specify only highest grad Elementapy/Secondary (0-12)	cation le completed) College (1-4	lor 5+)	16a. Dec (Giv life.	edent's Use re kind of w DO NOT	ork done d use retired	ation during most	of working	ng	16b. Kind of Bu	100	
Wild be filed Mental Hygiericked other	To Be Co	17. Father's Name (First, Middle, Last) Herman	Y	oung				18. Mother Pame 1		(First, Middle,	Maiden Surnam		
		19a. Informant's Name/Reletionship (T) Pamela White/Mothe		N.		ling Addres				MD 20	er. City or Town, 657	State, Zip Code	9)
ermit. Pages 1 and Department of Health Mportant: if item 27 nny Injury or other tr		20a. Method of Disposition 1 □ Burial 2 □ Cremetion 3 □ I 4 □ Donation 5 □ Other (Specify,			Place of Displacements, cr				3/	Date / 9/00	20c. Location - Dunkirl		Stete
permit. Pages 1 Department of I Important: If Na eny Injury or ot	1300	21. Signature of Funeral Service Licens						ss of Facility	Sev		neral Ho e Frede		D 20678
tificate be assecuted go physician and set the burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	Due to (a	r as a conse	equence of	r.						
desth cer attendin	Physician/Mec	Part II. Other significant conditions co	d	th but not res	ulting in the	underlying	cause civ	en in Pert I.		23b. Did	obecco use cor	ntributa to the	causa of death?
res that the igned by the be detache	by Phys										Yea 2□ No	3 Probably	
aw requi	Completed b				1						an autopsy med?	availabl	utopsy findings e prior to tion of cause 17
F 46	So									100	res 2□ No	1XYes	2□ No
Physicien: The I this certificate hard rai director, page	a a	25. Was case referred to medical examiner?	lospital:				On Oth	er		(Check only o			
Attending Ph ir deeth. ector: After th by the funeral	Certification: To	1 Nes 2 No 27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Data of (Month, 3 - 2 28e. Place o		28b. Time Injury	of 2AM	28c. Injun Work	4U NU	No C	perator fixed	Street and Numb	cycle th	T SCENE at struck ne Number,
To the Hospital or within 24 hours after To the Funeral Director	edical Ce	29a. Certifier (Check only one) 1 Certifying Phy (Check only one)	ner: On the bas	is of examina		th occurred					cause(s) and me		cause(s)
of the of the omple	Me	29b. Signature and title of Cedifier	and manne	sieled.	. ()	29	c. Licens	e number			29d. Date signe	d (Month, Day,	Year)
8 = 8 = 8		30. Name and address of person who or	tane	1	1-1),	0.	C.M.E	Ξ			H 2, 20	
10		(Josep	n fes	tane (1	11 Pe		reet,	Balt	Limon	re, Mar	yland 2	1201	
S Regis	tate strar	31. Date Med Month, Day, Year) WAR 0 6	2000 ▶	pistray's Signa	nure -	6.	1	- 11					

FOR STATE REGISTRAR

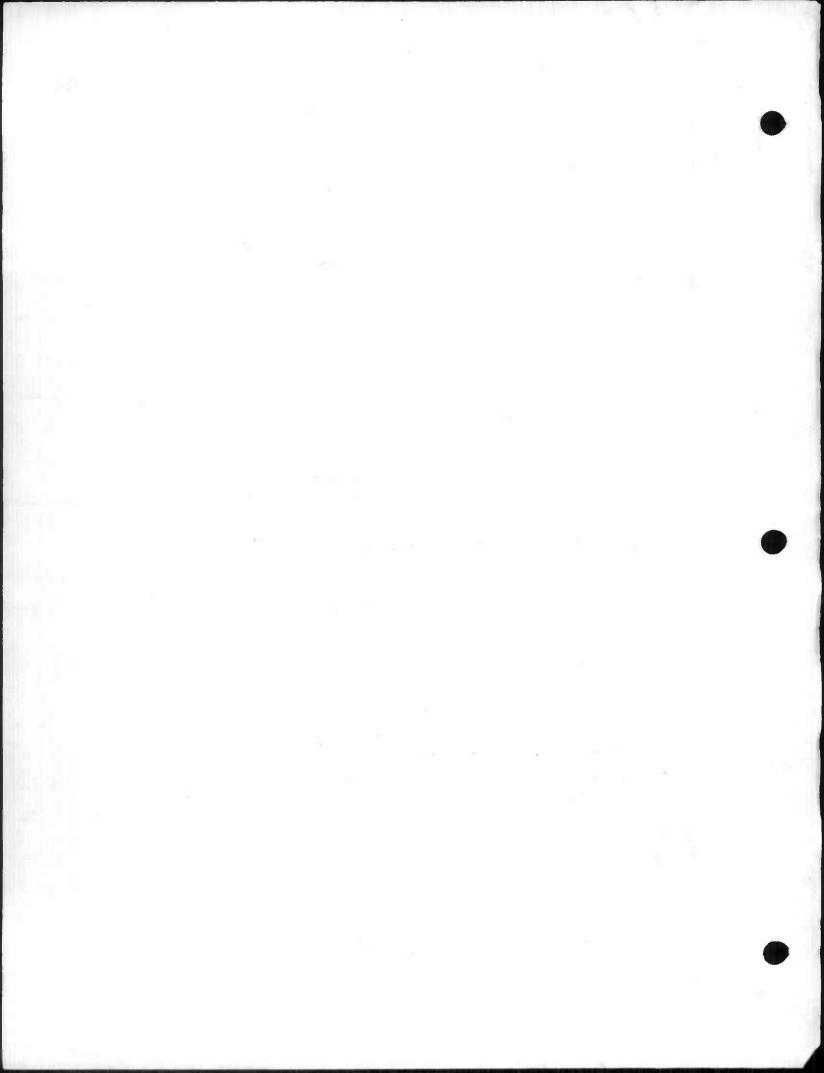
1. DECEDENT'S NAME (First, Middle, Last)

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	1. DECEDENT'S NAME (First, Middle, Last) Susan Irene Hill Alger				2. DATE OF DEATH MONTH Feb. 26.	2000 YEAR	3. TIME OF DEATH 6:10 A M
	4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs.	lest birthday) N	F UNDER 1 YEAR	IF UNDER 24 HMS.	7. DATE OF BIRTH		HPLACE (State or Foreign
	236-74-0088 1 D M 2 [XF 51	YRS.	ONTHS DAYS	HOURS MIN.	(Month, Day, Year) 01/01/19	Count	omb. Miss.
_	9a. FACILITY NAME (If not institution, give street and number)			OR LOCATION OF DE		9c. COUNTY OF C	EATH
CTOR	Frederick Memorial Hospital		Freder	ick		Frede	rick
DIREC	10a. STATE 10b. COUNTY		TOWN OR LOCAT	rion			10d. INSIDE CITY
	WV Jefferson	Rai	nson				LIMITS? 1 YES 2 XNO
FUNERAL	109 Orchard Drive			25438		US	WHAT COUNTRY?
BY FUN	11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced 12. WAS DECEDENT EVER IN U.S. FORCES? 1 YES 2 IF YES, OIVE WAR OR DATES	ARMED NO	If yes, sp	ENDENT OF HISPAN ecity Cuben, Mexices NO Specify	IC ORIGIN? (Specify Yes n, Puarto Ricen, atc.)	or No- 14, RACI Blac Spec	E — American Indian, k, Whita, atc. //y: White
8	15. DECEDENT'S EDUCATION (Specify only highest grade completed)	DECEDENT'S US	UAL OCCUPATION	ON	16b. KIND OF BUS	INESS/INDUSTRY	WILLE
PLET	Elementary/Secondary (0-12) College (1-4 or 5+)	(Give kind of work life. Do NOT use n	etired.)	or or working .brariar	Charle	s Town Libi	rarv
be notified at once. TO BE COMPL	17. FATHER'S NAME (First, Middle, Last) Grayson William Hill		21.0	18, MOTHER'S NAI	ME (First, Middle, Melden :	Sumame)	
diffed a		19b. MAILING AD	DRESS (Street a		bute Number, City or Town		
100	Jennifer G. Butrick			l Dr. Ra			3
	20a. METHOD OF DISPOSITION 1 Suriel 2 Cremetlon 3 Removal from State	CE AND DATE OF C	nlacel			CATION — City or To	
E	4 Donation 5 Other (Specify) 21. SIGNATURE OF FUNERAL SERVICE LICENSEE	cremetory or other e Hil.		etery 2/	/29/00 Ch	arles 1	Town, WV
medical examiner must	· Robert C. Fields		Jeffe	erson Ch	napel Fun		
Cale	23. PART I. Enter the diseases, or complications that caused the	death Do not	PO Bo	x 838 (Charles T	own, W	
# 6	immediate cause (Final disease or condition resulting in death) a. OUE TO (OR AS A CONS	ine.				etory arrest,	Approximats interval Batween Onset and Death
even	OUE TO (OR AS A CONS	SEOUENCE OF):	10.0	2 5.10		20	- \/
ry, or other traumatic event, CERTIFICATION	Sequentially list conditions, if any, leading to immediate	SEQUENCE OF):	NEO	KOENDI	OCRING (CANCER	2 month
CAT	cause. Enter UNDERLYING CAUSE (Disease or injury						
oth H	that initiated events DUE TO (OR AS A CONS resulting in death) LAST	SEOUENCE OF):					
	d						
vs any injury, EDICAL CE	PART II. Other significant conditions contributing to deeth but no	t resulting in t	tha underlying	g ceuse givan in i	Part I. 24a. WAS AN PERFORE		WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO
OWS any					1 [] YES 2	NO	OF DEATH?
5 5 5	DID TOBACCO USE CONTRIBUTE TO CAUSE OF DE	ATH YES	□ NO Ø	UNCERTAIN			1 YES 2 NO
ed, or Item 23 a PHYSICIAN:		ACE OF DEATH	Check only one)				
IYSI	1 YES 2 NO 1 Inpettent 2 ER/Outpettent	3 DOA 4		e 5 🗆 Residence (6 Other (Specify)		
marked, BY PH	1 Netural 5 Pending (Month, Day, Year)	28b. TIME O	y wo	URY AT RK? 'ES 2 NO	28d. OESCRIBE HOW IN	JURY OCCURED	
28 Is	2 Accident investigation 3 Suicide 8 Could not be datermined 26a. PLACE OF INJURY — At building, stc. (Specify)	home, farm, stree	et, factory, office		28f. LOCATION (Street as City or Town, State)	nd Number or Rural f	Route Number,
If Item 2	29e. CERTIFIER (Check only CERTIFYINO PHYSICIAN: To the best of my knowledge,	death occurred a	rt the time, data	and place, and due	to the cause(s) and man	ner as stated.	
	one) 2 MEDICAL EXAMINER: On the besis of examination and/o	or investigation, i	n my opinion, d	eath occured at the t	lme, data and place, and	due to the cause(a) and manner sa stated.
IMPORTANT TO BE COI	HCGAU [MD			D 441	BER 4	≥ 3-9	(Month, Day, Year)
	30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (1) A. Z. HEGAZI 801 TOLLHON	use Au	n D	3, Free	wich M	0 217	s l
	31. DATE FILED (MONTHOR YOU) 7 2000 32. REGISTAR'S SIGNATURE	B.	Spark				
							DHMH-16 Rev 1/89

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE O CERTIFICATE OF DEATH REG. NO.

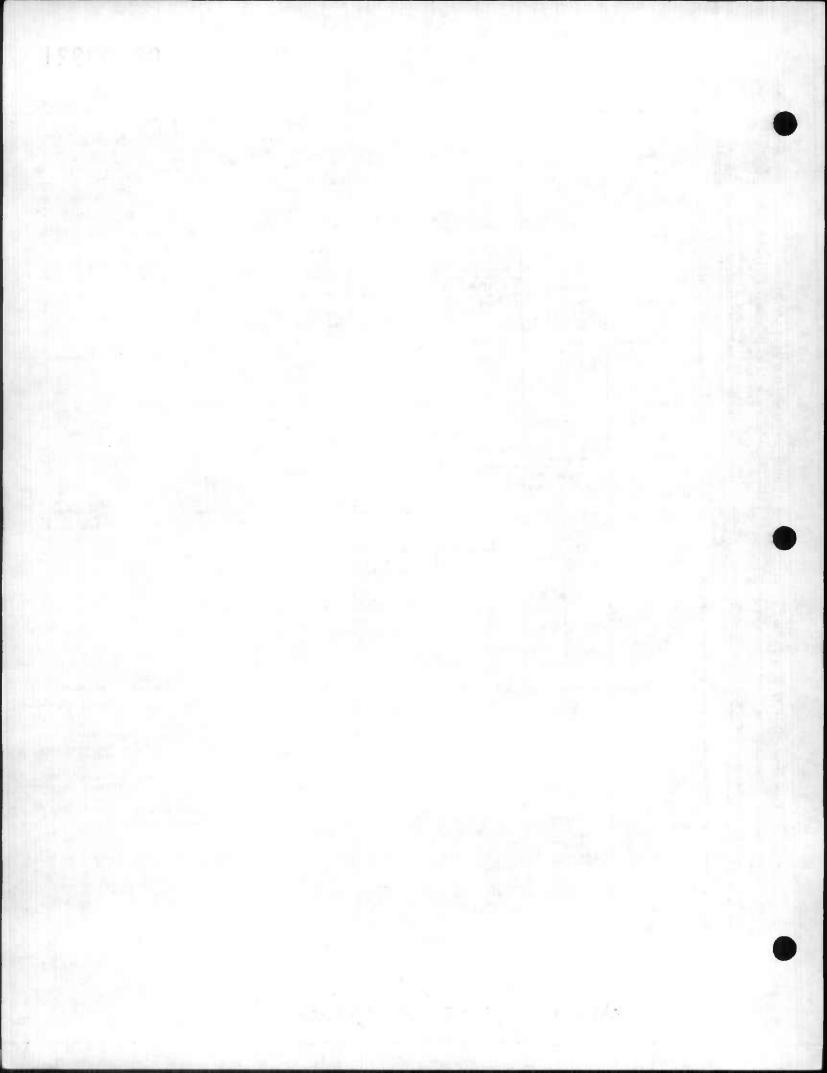


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State of Maryland / Department of Health and Mental Hygiene 00 08921

			Certificate	of Death	Reg	3. No.	00321
Discolution	1. Decedent's Neme (First, Middla, La	st)			2. Data of Death Month	Day Yea	3. Tima of Death
Physician /Medical	Bertha V. B	ennett			March 1	-	
Examiner	4a Facility Name (If not institution, giv	e street and number)		4b. City, Town, or L	ocation of Death	4c. County of Di	
	Stella Maris	12 4- 0	last hirthday) If Under 1 Y		um	Balti	
Funeral Director	5. Social Security Number 6. S 212-09-3314	ex 7. Age (In yrs. I		ays Hours Min.	8. Date of Birth (Month, Day,) JUNE 4	(ear) ,1911 M	Birthplace (State or Foreign Country) aryland
M M	10a. Stete 10b. County	10c. City	r, Town or Location	4 3 7 5			10d. Inside City Limits
death with the Marylar me 23e or 28e f show mast be notified at neral Director	MD Baltim	ore 0	wings Mill		100	g. Citizen of What	1 ☐ Yes 2 🖫 No Country?
Sa or	12 Comill Cour	t, Apt. 2B	211	17		JSA	
d 2 should be filled within 72 hours after death vin and Mental Hygiene. The marked other than "natural", or hams 23 traumatic event, the Medical Examiner must To Be Completed by Furneral	11. Marital Status 1 Never Merried 2 Merried 3 💢 Widowed 4 Divorced	12. Was Decedent Ever in U, Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	S. 13. Wes Decedent If Yes, specify	of Hispanic Origin? (Sp Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)	Black, W	merican Indien, hite, etc. hite
2 hou	15. Decedent's Ed	lucation	16a. Decedent's Usual O	ccupation	16	6b. Kind of Busine	
ed within 72 ho ygiene. he than *natur A, the Medical.	(Specify only highest grade Elementery/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use n	one during most of work etired)	ang		
Con Con	12		Clerk			Retail	Store
Sabba e	17. Father's Neme (First, Middle, Last)				e (First, Middle, Ma		
To To	Rudolph Kraus		T		nna Czi		
and 2 st saith and n 27 is n ser traum	Richard Bennet	t/son		Ct., Apt. 2	B Owings	s Mills,	MD21117
Pages 1 ment of H ant: If the ury or off	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donetion 5 Other (Specify	Removel from State	lace of Disposition (Name of emetery, crematory or other ro Crematory	, Inc. 3/16	5/00 I	Baltimo	re, MD
Dermit. Depart Import any inj	21. Signature of Euneral Service Licer Thomas Grego	u-	22 Neme and A Cremai	ddress of Facility 10n Socie rederick 1	ety of N	laryland	d, Inc.
	23e. Pert1. Enter the diseese, or com shock, or heart failure. List only						Approximate Intervel Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in deeth)	Lunc	Cancel as a consequence of):				Onset end Deeth
n and ial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or	r es a consequence of):				1
ntificate be ng physicia as the bur Medical	Gause (Disease or Injury that initieted events resulting in death) Last	CDue to (or	as e consequence of):			70	
es that the death ce igned by the attendil be detached for use by Physiciary	Pert II. Other aignificant conditions or	ontributing to death but not resu	ulting in the underlying caus	e given in Pert t.	23b. Did tob	acco use contrib	uts to the cause of death?
ed by detacl					1 Yes	8 2□No 3□	Probably 4 Unknown
been s should leted					24a, Was an performe		b. Were autopsy findings available prior to completion of cause of death?
The law ate has begge 2 a					1	2 157 No	1 ☐ Yas 2 ☐ No
Physician: The law this certificate has at director, page 2: To Be Comp	25. Was case referred to medical			26. Place of Deal	th (Check only one		70 100 20110
Physician: this certific ral director, TO Be	examiner? 1 ☐ Yes 2 ☑ No	Hospitel: 1 Inpatient 2	ER/Outpatient 3 DOA	0.1			pocity) Huspice
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 1	27. Menner of Death 1 (ZNeturel 5 Pending 2 Accident investigation	28a. Dete of Injury (Month, Day Year)		Injury at Work?	28d. Describe how		
tal or Attanding P rs after death. al Director: After t ied in by the funera Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At ho building, etc. (Specify		fice	28f. Location (Stre City or Town,	net and Number or State)	Rural Route Number,
To the Hospital within 24 hours to the Funeral completely filled	29a. Certifier 1 Certifying Ph (Check only 2 Medical Exert	ysician; To the best of my know liner: On the basis of examineti and menner steted.	viedge, death occurred at the ion end/or investigation, in	ne time, date and place, my opinion, death occur	and due to the cau red at the time, dat	ise(s) and manner e and plece, and o	as steted. due to the ceuse(s)
within 24 To the Fu complete	29b. Signatura and title of certifier		29c, Li	cense number	290	d. Date signed (Mo	onth, Day, Year)
	167		D	43725		3/15	100
20	30. Nama and eddress of person who of TARIG MAHD	completed cause of death (Item	23a) (Type, Print)	Giver Noc	k Road	Balh	MD 21221
State	31. Date filed (Month, Day, Year)	32. Registrar's Signat	b. So				
Registrar	MARC I 1 2	000	1. 1000	Ells/			

DHMH 16 Rav 6/95

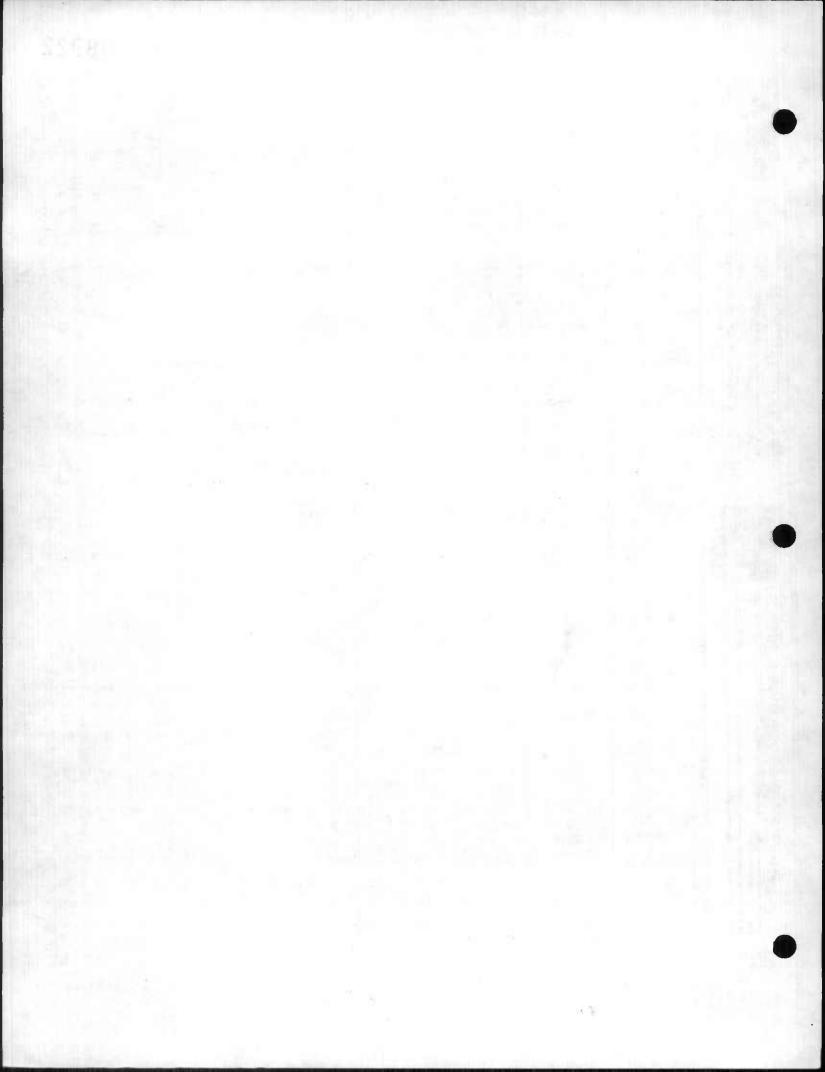


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State of Maryland / Department of Health and Mental Hygiene 00 08922

						Ce	rtifica	te of	Death			Reg. No.			
		1. Decedent's Name (First, Mide	die, Last)								2. Date of De			3. Tima of De	eath
Physic		LOUISE	В	ARTEL	S						MARCH 1	5 2000	Year	2:10	pm
/Medi		4a Facility Name (If not institution							4b. City. To	wn. or L	ocation of Death		ty of Death		-
Exami	ner		21-00-0210	_										DE COUNT	TT 7
eli:		CATONSVILLE C			7 4 0-	t t ' t - 1	If I lade	er 1 Year	If Under	NSV.				RE COUN	
Funeral		5. Social Security Number	6. Sex	2DXF		. last birthday) Yrs.	Months		Hours	Min.	8. Date of Bird (Month, Da	h y, Year)	9. Birth	place (State or F ntry)	oreign
Director		215-18-9504			86	115.					Sept. (14 1913	Vir	ginia	
D .		Usual Residence of Decedant 10a. Stete 10b. Count			100 0	h. Tour out	antine.						1		
alyla aho	No.		'			ity, Town or Lo								10d. Inside City I	
M THE	cto	Md. n	ı/a		В	altimo	re							1 XYes 2	□ No
4 22 F	Director	10e. Street and Number					10f. Z	ip Code				10g. Citizen of	What Cour	ntry?	
w eg	JE D	1508 Battery	Ave.					2	21230		4		USA		
72 hours after death with the Maryland natural', or items 23s or 28s-f show deal Example must be notified	Funeral	11. Merital Sietus	12.	Was Dece	deni Ever in U	J,S. 13.	Wes Dece	edent of h	lispanic On	igin? (Sp	pecify Yes or No Rican, etc.)	14. Re	ce - Americ		
1 44	FU	1 Never Married 2 Ma	rried	Armed For					an, Mexicai	n, Puerto	Rican, etc.)	Bio	ack, White,	114	
d within 72 hours at giene. or than "natural", or	by	3 ₩Widowed 4 Divorce		1 ☐ Yes If Yes, Giv Year or Da	ates:		1 Yes	20X No	Specify:			Speci	ly: W	hite	
2 hou	2	15. Decede				16a Dace	dent's He	ual Occur	ation			16b. Kind of I	Rusiness/In	dusto	
C * 4	Completed	(Specify only high	est grade co	ompleted)		16a. Dece (Giva lifa.	kind of w	ork done	during mos	t of work	ing	TOD. THIS OF	703111033r111	oostry	
within then	E	Elementary/Secondary (0-12)		College (1	-4or 5+)		e Mak		-/		100	Home	Owne:	r	
be filed withing tall Hygiene. d other than		17. Father's Name (First, Middle	d not)	0					40 44-14	ada Massa	a (First, Middle,				
d 2 should be file th and Mental Hy ?? Is marked othe traumatic avent	Be			_									mej		
should be nd Mental marked o	10	Charles Karl	Flider	S					Jer	mett	te Lawso	on			
d 2 sho th and 7 is me traum		19a. Informant's Name/Relation	ship (Type,	Print)		19b. Mailie	ng Addras	ss (Street	and Numb	er or Rui	ral Route Number	er, City or Town	n. State, Zir	Code)	
1 and 2 Health am 27 I		Linda Moreau	(Dat	ighte	r)	321	Sto	newa	11 Ro	ad,	Baltimo	re, Md.	2122	28	
f Heall	7	20a. Method of Disposition				Place of Dispo	sition (Na	ame of			Date	20c. Location			
semit. Pages 1 ar Department of Hea mportant: if Itam 3 iny Injury or other MGB.		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (oval from S	State	dar Hi				3/18	3/2000	Brook]	m Da	rk, MD.	
permit. Pages 1 an Department of Heal Important: If Itam 2 any Injury or other pnce.		21. Signature of Funerat Service							ss of Fecili		72000	DIOOKI	yll Fa	IN, III).	
me od		21. dignature of quietat Service	Licensee	1	/	24					k Funera	1 Home	P.A.		
. 00244		Manuel	a . 1	V/ar	lo			_	_		Baltin			230	
		23a. Part T. Entar the disease, of shock, or heart failure. Lis	or complicat	ions that co	aused the dea	th. Do not ent	er the mo	de ot dyi	ng, such as	cerdiac	or respiratory a	rest,	i	Approximata Interval Batwe	en
Physician			,											Onset and Dea	
/Medical		Immediate Causa (Final											1		101
Examiner		disease or condition resulting to death)	8	Br		-pneur							1	One Wei	ek_
	6					or as a consec							1		
pe insu	H		b	Al		er's I			3				1	Years.	
and Il-tra	xai	Sequentially list conditions, if any, leading to immediate cause. Entar Underlying			Due to (or as a consec	quence of):					i		
cian buris	-	Cause (Disease or injury	G										i		
certificate be executed ding physician and use as the burial-transit	edical Examiner	that initiated events resulting in death) Last			Due io (or es e conseq	uence of)	1:							
entifica ding p	Ne le												1		
0 63	5		0												
e death the stter hed for u	SIC	Part II. Other significant conditi	lons contrib	uting to de	ath but not res	sulting in the u	ndertvina	ceusa di	en in Part i	1.	23b. Did 1	obacco usa c	ontributs t	o the causs of o	death?
the ach	Physician											Yes 200 No		bably 4 Un	
es deta	ру Р	Osteoart	hrit	is_							"	100 10(110	0[].10		
he law requires to has been signed age 2 should be	d b										24a Was	an autopsy	24b. W	ere autopsy find	dinas
requir been s should	ete	Glaucoma										med?	81	vailable prior to empletion of cau	
has by	Completed													death?	
- to d	00										101	as 2 No	11	Yes 20 No	0
ysician: The	Be	25. Was case raterred to medic	el						26. Place	e of Deal	th (Check only o	ne)	,		
	To	examiner? 1 ☐ Yes 2⊠ No	Hos	oitat:	npatient 2	ER/Outpatier	nt 3 🗆 D	OA Ott	er: 41X No	ursina Ho	ome 5 Resid	dence 6 □O	ther (Speci	(v)	
5 5 7		27. Manner of Death	1		of Injury h, Day Year)	28b. Time of		28c. Inju			28d. Describe			.,,	
l or Attending siter death. Director: Atte d in by the fune	5	1 Natural 5 Pendi	ing tigation	(Monti	h, Day Year)	injury	М		rk? Yes 2□	No					
or Attending P ster death. Director: After t d in by the funer	Certification:	3 Suicide 6 Could	not be	19a Diago	of Injury At h	ama farm at					29f Location /	Street and Alum	har or Pur	al Route Numbe	
Sfer Sfer Direct	흔	4 Homicide determined	mined 4	buildir	ng, etc. (Speci	nome, farm, str ify)	eet, racto	ry, onice			City or Tox		iber of riun	al rioule reunibe	,
led led															
Hospital 24 hours Funeral stely filled	edicai										and dua to the red at the time,				
Pet Plet	8	one)	LABITATION	and mann	ar stated.	2001 911401 111	restigation	.,y c	pilitori, dee	ilii occur	reo at the time,	oate and place	, and doe t	o tilo ca doo(s)	
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Σ	29b. Signeture and title of certific	91 00	M.	1		29	c. Licens	e number			29d. Date sign	ed (Month,	Dey, Year)	
		N-13.	Call	SWA	4			d 30	469			March	16	2000.	
1		30 Name and address of passes	who some	lated save	a of danth (It-	m 22a) /T.m-					1		. 0 /	2000.	
0		30. Name and addrass of persor										LE HAR			
		N B Vellanki		90!	55 Che	vrole	t Di	rive	#1	00,	Ellic	ott Ci	ty,	MD 210	42.
Sta	-	31. Date filed (Month, Day, Year MAF	17	32. Re	egistrar e Sign	aftire	LA	1							
Registr	ar	1ATAT	TI	-WUU	Pro-		N.	131	Belo	No.					

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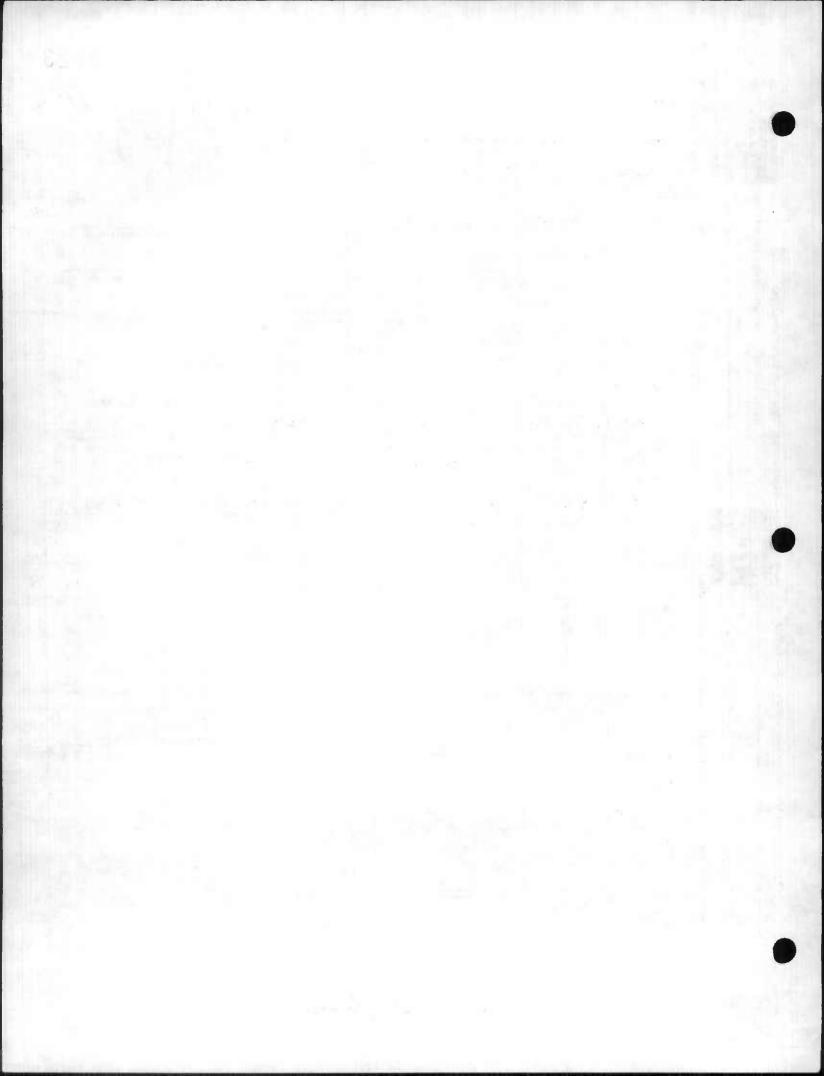


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State of Maryland / Department of Health and Mental Hygiene 0 0 8923

				Certifica	te of	Death			Reg. No.	U	0 3 2 3
Physician	Decedent's Name (First, Middle Yung Ja Butler							2. Data of De Month MARC	eath Day	Year 2000	3. Time of Death
/Medical Examiner	4a Facility Nama (If not institution	, give street and numb	per)			4b. City, To	wn, or Lo	ocation of Deal			
LAdiiiiici	Stella Maris H	ospice at	Mercy Hos	spital		Balti	more				
Funeral Director	5. Social Security Number 214–82–6957	6. Sex 7.	Age (In yrs. last bit	rthday) If Und Month	er 1 Year S Days	If Under Hours	24 Hrs. Min.	8. Date of Bi	rth ay, Year) 16,1934		Nace (Stata or Foreigntry)
	Usual Residance of Decedant							riar cir	10/1334	101	ca
with the Maryland a or 28a-1 show be notified at	10a. Stata 10b. County		10c. City, Tow	n or Location						1	Od. Inside City Limits
oto all o	MD Anne	Arunde1	Seve								1 ☐ Yes 2(2XN
or 2	10e. Street and Number			10f. 2	ip Code				10g. Citizen of	What Coun	try?
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ar, or the	11. Merital Status 1 Never Married 2 Marri 3 Widowed 4 Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yas, Giva Yaar or Date	as? No		edent of I ecify Cub 2 No	fispanic Ori an, Mexicar Specify:		ecify Yes or No Rican, atc.)	Specif	ce - Americ ck, Whita, iy: As	
ed within 72 hours ygiene. wr then "neturel", r, tre Medice E.	15. Decedent		16a	Decedent's Us	ual Occup	ation	t of work	ina	16b. Kind of B	usiness/Inc	dustry
	(Specify only highas Elemantary/Secondary (0-12)	College (1-4	or 5+)	(Giva kind of v lifa. DO NOT	use retire	d)	t OF WORK	riy			
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should be and Mental and Mental and Mental and Mental and Mental	Song Im Sun					Ki	m Ss	hi			
and le ma	19a. Informant's Name/Raletionsh		19t	. Mailing Addra	ss (Street	and Number	er or Run	al Routa Numb	er, City or Town	Stata, Zip	Code)
and n 27	Fred Butler (Hu	sband)	_			Cour			MD 2114		
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic avent, the Monce. To Be Comp	20e. Method of Disposition 12 Buriel 2 Cremetion 4 Donation 5 Othar (Sp		ata cemata	f Disposition (N ny, crematory of ton Nat	other pla		1	3/20/ 2000	20c. Location	Tribay.	wn, Stete Virginia
permit. Pa Departmen Important: any injury once.	21. Signatura of Funaral Sarvice L	icensee	7	22. Nama	and Addra	ss of Facilit	ty				
Depariment in permit in pe	Michel.	(4 K	tta		_			Home, I		D 054	0.1
	23a. Part1. Entar tha disease, or	complications that cau	ised the deeth. Do						oolis, M	D 214	Approximate
/Medical Examiner	Immediata Causa (Final disaesa of condition resulting in death)	· an	Due to (or as a	Enco consequence Tras	oha	lop	ath	ly .		1	1 month
icate be executed physician end s the burial-transit	Sequentially list conditions, if any, leeding to immadiata cause. Enter Underlying Causa (Disease or Injury		Due to (or es a	consequence o):					‡ 1	
M S	that initiated events rasulting in death) Last	d	Due to (or es e	consequence of):						
death of attended for u	Part II. Other significant condition	na contributing to deat	h but not rasulting i	n the underlying	cause giv	ren in Part I	l.	23b. Did	tobacco use co	entribute to	the cause of deat
ned by the detache	Hypertension							10	Yea 2 No	3 Prol	bably 4 Unkno
The law requires that the death certific are has been signed by the attending p. page 2 should be detached for use as Completed by Physician/Me	Peripheral	Vasula	1 Desea	isl.					s an autopsy ormed?	av	ere autopsy findings ailable prior to mpletion of cause death?
vicion: The lav certificate has rector, pege 2 Be Comp	Conferences	reiles a	ani dan	* .				10	Yas 20 No	1[Yes 2□ No
artifica octor, p	25. Wes case referred to medical	20 -07 W	COCO OF IL			26. Place	of Deat	h (Check only	ona) \$7-5//	A M	apis At 1
Physician: this certific iral director, TO Be	axaminar?	Hospital:	atiant 2 ER/O	utpatient 3 1	OA Ott	100			idence 6 Ott	nar (Specif	HOSDIC
ding Physith. After this funeral distribut. To	1 Yas 2 Sho 1 Inpatiant 2 ER/Outpatient 3 DOA Outer 4 Nursing Home 27. Menyaer of Death 28a. Data of Injury 28b. Tima of Injury 28c. Injury at Work? 28c. Accident 1 Yes 2 No								how injury occur		Maspie
tal or Attending P rs after death. al Director: After tel led in by the funer. Certification:	2 Accident Invastig 3 Suicide 6 Could n 4 Homicida determi	ot be 28a. Place of	Injury - At homa, fa , atc. (Specify)	ırm, street, facto	ory, office				(Street and Numi wn, State)	ber or Rura	il Route Number,
To the Hospital or Attending Philipping Carbon 24 hours after death. Completely filled in by the funeral completely filled in by the funeral Medical Certification: 7	29a. Certifier Certifying (Check only one)	Physician: To the besicantner: On the basic	s of examination an	, deeth occurre d/or Invastigation	d et tha tio	na, date an pinion, dea	d place, th occurr	and dua to tha red at tha tima,	cause(s) and m date and place,	annar as st and due to	lated. tha cause(s)
Within on the complete on the	29b. Signeture and title of certifier	•		2	9c. Licens	e number			29d. Data signe	d (Month,	Day, Year)
- 5 - 0	De la	Phus m			1 1	100	54		Mana	1	14 2000
10	20 Name and address of a	to complete	of dooth there on t	(Time Print)	2	08	37		MAKE	1	11,0000
4)	DITVID NICE.	DERG	3015	TPA U	1 1)/		BAI	Himor	RE,	nd 2120:
State Registrar	31. Data filed (Month, Day, Year) MAR 1 7	2000	Istrar's Signatura	19. p	park	2				•	

C DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month Year VIOLET BATZE 9:04 PM MARCH 2000 13 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL CENTER BALTIMORE If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Yeer Months Days 5. Social Security Number Birthplaca (State or Foreign Country) Days 1 M 200 F 220-14-4030 76 12/01/1923 Illinois Usual Residence of Decedent 10s State 10b County 10c. City. Town or Location 10d. fnside City Limits 1 ☐ Yas 2 No Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2704 Daisy Ave. 21227 USA 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 MNo ff Yes, Give Yeer or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 XNo Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Administration Sales Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Walter R. Ambrose Violet Yost 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Batze Jr. Son 2704 Daisy Ave. Baltimore, MD. ace of Disposition (Name of Dele 21227 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 03/16 Baltimore, MD. 22 Name end Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 21. Signature of Funeral Service Ligensee 736 Edmondson Ave. Baltimore, Md. 21228 detions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Deeth tmmediate Cause (Final disease or condition resulting in death) BACTERIAL MENINGITIS ONE WEEK Due to (or es e consequence of): MASTOIDITIS TWO WEEK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) OTITIS MEDIA Due to (or es a consequence of) Part it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert it. 23h Dtd tohacco use contribute to the cause of death? 1 Yes 2 No 3 robably 4 Unknown EMPHYSEMA 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was en eutopsy performed? 218 No 1 ☐ Yes 2 No 25. Was case referred to medical axaminer? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes 2No 1 Dipatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Physician /Medical Examiner

Department of Important: If any Injury or page

Physician

/Medical

Examiner

Funeral

Director

"natural", or flems 23a or 28a-f ahow

Pages 1 and 2 should be filed within 72 hours after death neart of Health and Mental Hygiene.
Intel If Health and Mental Hygiene.
Intel If Hear 27 Is marked other than "natural", or home 23 and if I have 12 and 12 or other treumatic event, the feature of the treumatic event, the feature in the most present of the page 12 or other treumatic event, the feature of the page 12 or other treumatic event, the feature of the page 12 or other treumatic event, the feature of the page 13 or other treumatic event, the feature of the page 13 or other treumatic event, the feature of the page 13 or other treumatic event, the feature of the page 13 or other treumatic events.

Baltimore, Maryland 21215-0020

Director

Funeral

Completed by

the Maryland

Physician/Medical Examiner

ician and burial-transit physician the burial for use signed by the a funeral director, After this

or Attending Physician: The lew requires that the death certificate be axecuted Box 68760. P.O. 1 Division of Vital Records. within 24 hours after death. To the Funeral Director: A filled in by To the Hospital

completely State Registrar

þ Completed Be Certification: To

Medical 29b. Signature end title of certifier TAKE-OXLEY QING

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

(Check only one)

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number 12136

1 Yes 2 No

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and place, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year)

MARCH 13 2000

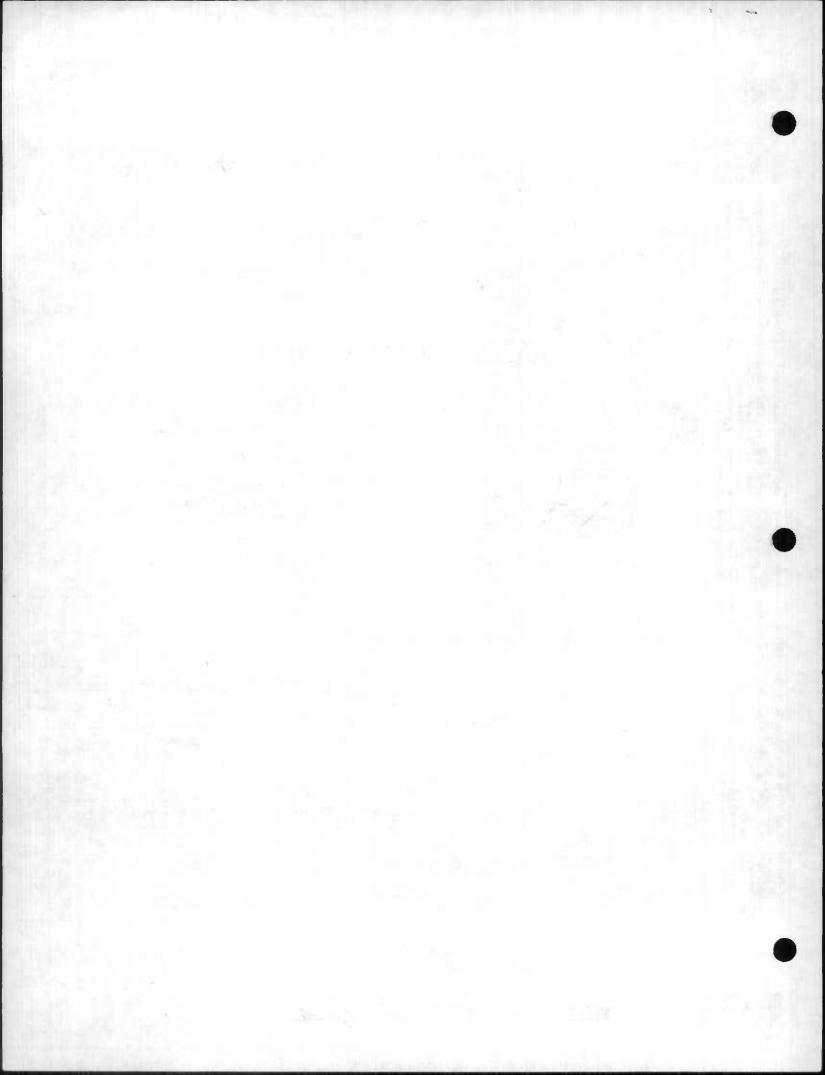
28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

, MD BALTIMORE, MD 2/223 HANOVER 8. ST. 3001

31. Dete filed (Month, Day, Year) 32. Registraf's Signature MAR 1

6 Could not be determined

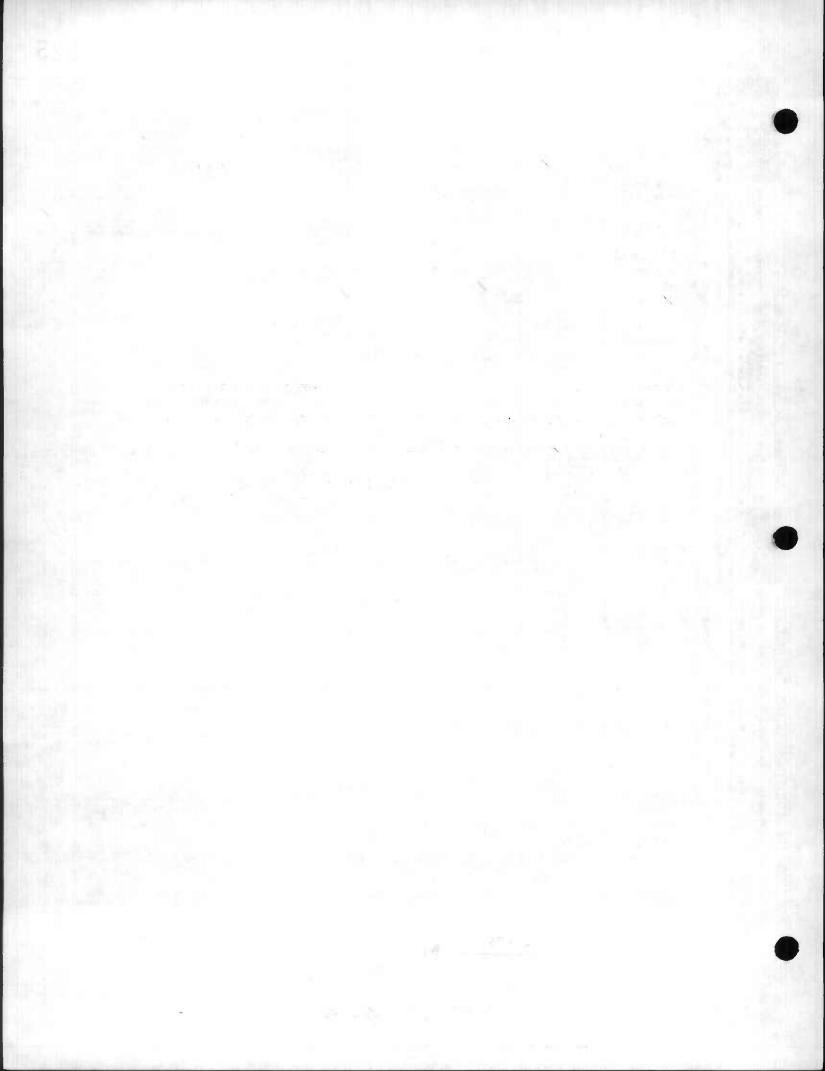


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State of Maryland / Department of Health and Mental Hygiene 00 08925

				Certific	cate of	Death		Reg. No.		
ician	Decedent's Name (First, Middle, Last)						2. Date of De Month		Year	3. Time of Death
dical	Willis Bo	sse					03	Day 13	2000	4:20 p
niner	4a Facility Name (If not institution, give						Location of Deat			
	Fernbrook Ass	istive L	iving			0den	ton	Anne	Aru:	ndel
al	5. Social Security Number 6. Se		In yrs. last bii	rthday) If Ur Mont	nder 1 Year			th Year)	9. Birthpla	ce (Stete or Foreign
or	216-09-4618	M 20 F	85	Yrs.	uiis Days	THOUS IN	02/21/	1915	MD.	,
	Usual Residence of Decedent									
	10a. State 10b. County	1	Oc. City, Tow	n or Location					10	d. Inside City Limits
ector	Md. Anne Arun	ndel	Odento	on						1 Yes 2 No
Direc	10s. Street and Number	IGCI	ouche		. Zip Code			10g. Citizen of	What Count	y?
	1190 Monie Rd.				21144			USA		
970	11. Marital Status	12. Wes Decedent Ev	er in U.S.	13. Wes De			Specify Yes or No		ce - America	n Indian,
Funeral	1 Never Married 2 Married	Armed Forces?		If Yes,	specify Cub	an, Mexican, Puè	Specify Yes or No rto Rican, etc.)	Bla	ck, White, e	lc.
by	3 Widowed 4 Divorced	If Yes, Give Year or Detes:		1 ☐ Ye	s 2 No	Specify:		Specif	y: _{1.7}	hite
	15. Decedent's Edu	THE CAME	160	. Decedent's U	Havel Occur	nation		16b, Kind of B		
Completed	(Specify only highest grad		100	(Give kind of	f work done	during most of world)	orking	100. Kind of B	USINGSS/II IUI	iotry
E.	Elementary/Secondary (0-12)	College (1-4or 5+)	1			-5/				
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Be	17. Father's Name (First, Middle, Last)								116)	
To	Adenorum Bosse			Leve			Holmes Ti			
	19a. Informant's Name/Relationship (Ty						Rural Route Numb			Code)
	Darlene L. Meredi	th Daughte	er 20	007 Hi	llside	e Dr. Ba	altimore	Md. 21	207	
	20a. Method of Disposition		20b. Plece o cemete	of Disposition ((Name of or other ple	ice)	Date	20c. Location		
	1 ☐ Burial 2 ☐ Cremetion 3 ☐F 4 ☐ Donation 5 ☐ Other (Specify)		Volus	in, crematory	orial	Park.	03/16	Volusi	la, FL	•
	21. Signature of Funeral Service License			22. Name	e end Addri	ess of Facility	1			
	11 1				_		chwab Fui			
	T						. Baltimo		2122	8
	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications thet caused the ne cause on each line.	e deeth. Do	not enter the	mode of dyi	ng, such es cardi	ac or respiretory a	rrest,		Approximete Intervel Between
	0									Onset and Deeth
	Immediate Cause (Finat disease or condition	Pa	rkins	on's	Dise	ase				8 years
	resulting in death)	Du	ue to (or as a	consequence	of):				1	
Examiner										
E	Sequentially list conditions.	Dı	e to (or es a	consequence	of):					
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying									
edical	Cause (Disease or injury that initiated events	Du	e to (or as e	consequence	of):					
Per	resulting in death) Last									
5		1							i	
0	Part II. Other significant conditions cor	stributing to death but	not reculting i	n the underhei	ing cause ai	uen in Pert I	23h Did	tobacco una co	ontribude to	the cause of deat
Physician/	warm argument continues cor		raduling I	are driveriy	y vause gr	CONTRACTOR I.				ably 4 Unknow
								Yes 25 No	3 FIOD	of TOTIKNO
d by							24a Was	an autopsy	24b. Wei	e autopsy findings
Completed							perfe	ormed?	ava	lable prior to
up									of d	eath?
S							10	Yes 200No	10	Yes 2 No
Be	25. Was case referred to medical examiner?						eeth (Check only			
2	1 Yes 2 XNo	fospital: 1 Inpatient	2 ER/O	utpatient 3	J DOA		Home 5 Resi	dence 6XDOt	her (Specify,	Assisti
	27. Manner of Death	28a. Date of Injury (Month, Day Y	(ear) 28b.	Time of Injury	28c. Inju			how injury occu		Living
atic	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(М		Yes 2□No				
HIC	3 Suicide 6 Could not be determined	28e. Plece of Injury building, etc. (- At home, fe	erm, street, fa	ctory, office	3	28f. Location (City or To	Street and Num	ber or Rural	Route Number,
Certification:		building, etc. (эрвспу)				City or 10	mi, Siale/		
	29a. Certifier 1 Certifying Phys	ician: To the best of r	ny knowledae	e, deeth occur	rred et the ti	me, date end plac	ce, and due to the	cause(s) and m	anner as sta	ited.
edical	(Check only and Medical Examination)	ner: On the basis of en	caminetion an	nd/or investiga	ation, in my	opinion, death occ	curred at the time,	date and place,	and due to	the cause(s)
M	290. Signature and little of certifier	1 10			29c. Licen:	se number		29d. Date signe	ed (Month, E	lay, Year)
	1 desti	Slugh		0		14160		3/14	1/200	0
	Stron		M	DI						
	30. Name and address of person who co									
	Harjit Singh,	M.D. 54	10-A	Ritch	ie Hi	ighway	Baltimo	re, Md	. 212	225
te	31. Date filed (Month, Day, Year)	32. Pegistrer's	Signature	4	1	,				
	MAD 1 7 2001	Bener		17 A	TOR. W	- /				

DHMH 16 Rev 6/95



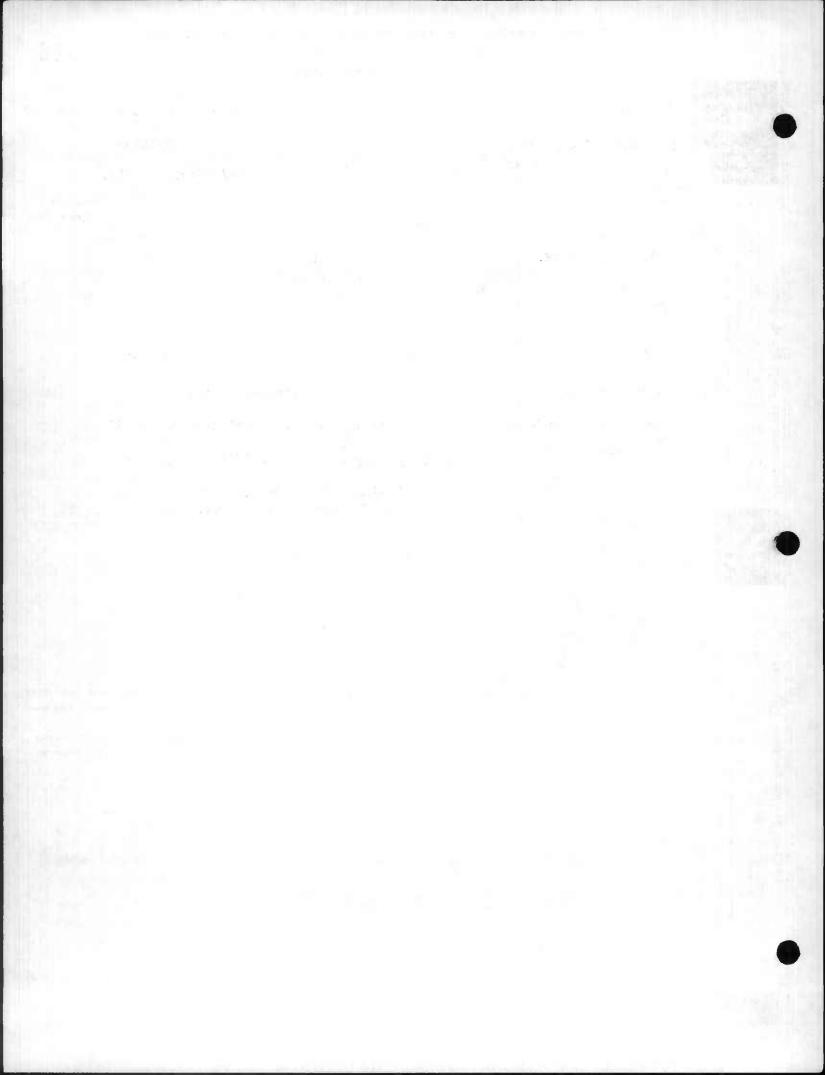
Please Type or Print in Black Indelible Ink. Assure All Coples Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Dete of Death 3. Tima of Death Month **Physician** YNNA 4:40 Am MARCH 2000 /Medical 4e. Facility Neme (If not Institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Loch Raven Eldercare Baltimore if Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) **Funeral** 1□M 25 F Days Yrs. Director 197-18-9627 73 01/30/1927 PA. Usuel Residence of Decedent the Marylend 10e. Stete 10h. County 10c. City, Town or Location Show 10d. Inside City Limits item 27 is merked other than "natural", or items 23s or 28s-f sho other trsumetic svent, the Medical Examiner must be notified at 1 XYes 2 □ No Director Baltimore 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 2401 Allendale Rd. death 21216 USA 14. Race - American Indien, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours efter 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 If Yes, Give Yeer or Dates: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 18e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Depertment of Health and Mental Hygiene. Important: if Item Z7 Is merked other than "rent Injury or other treumatic avantations." Elementery/Secondery (0-12) College (1-4or 5+) Homemaker 8 Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Malden Sumeme) Be 2 Herbert Adair Elizabeth Weinschnk 19e. Informent's Neme/Retationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie Brown Daughter 2401 Allendale Rd. Baltimore, MD. 21216 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removel from State 4 ☐ Donetlon 5 ☐ Other (Specify) Baltimore Washington Crem 03/14 Laurel 21. Signature of Funeral Service Lig 22. Name end Address of Fecility Bradley Ashton Matthews Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, more, MD. shock, or heart feiture. List only one ceuse on each line. Approximate Interval Between Onset end Deeth **Physician** /Medical Immediete Cause (Finet CEREPORO disease or condition resulting in deeth) Examiner Examiner DISORDER SCIZURE buriel-trensit certificete be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or Injury that Initieted events resulting in deeth) Lest and P.O. Box 68760. attending physician HYPER TENSION Physician/Medical the Due to (or as a consequence of) 98 ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 No No Nown signed b Records, þ 24b. Were autopsy findings evaileble prior to completion of cause of death? page 2 should Completed 24e. Wes en eutopsy performed? peed certificate hes 1□ Yes 2000 1 ☐ Yes 2 ☐ No Division of Vital 25. Wes case referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1□ Yes 2□No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 28c. Injury et Work? Certification: After . or Attending To the Hospital or Attending within 24 hours effer deeth.
To the Funeral Director: Afte completely filled in by the fund 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of tnjury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end piece, end due to the ceuse(s) and menner es steted.

2 Madtcat Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only 29b. Signature and title of centries 29c. License number 29d. Dete signed (Month, Day, Year) 152228 30. Name and edgess of person who completed cause of deeth (Item 23e) (Type, Print) 3007 G. NORTHERN PKWY BALTIMORE WMAR 18HADIYA, MID

32. Registrar's Signeture

State Registrar 31. Dete filed (Month



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08927 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year **Physician** MICHAEL 1500 N 11:56 Am 15 MANCH 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner THE JOHNS HOPKINS HOSPITAL 5. Social Security Number 6. Sex 7. Ag BALTIMORE CITY 7. Age (In yrs. last birthday) 39 Yrs. If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 10 M 2□ F 213 - 78-741 August 19, 1960 MARYLAND Usuel Residence of Decedent 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Directo 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21217 Stricker Street Funeral 12. Was Decedent Ever in U,S. Amed Forces? 1 Yes 2 No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, Whita, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorced Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 10th Mechanic Automotive 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Broom Frances Llarence Dowdy 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1129 N. Stricker St, Baltimore, MD 1 daughter Michelle A. Broom 21217 20a. Method of Disposition 1 Burial 2 Cremetion 3 Removal from State 20b. Ptece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 120/00 Randallstown 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 22. Name end Address of Facility WYLIE FUNERAL HOME PA 21. Signature of Funeral Service Licenses 638 N. GILMOR ST. BALTIMORE, MD 21217 286. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart leiture. List only one cause on each line. Approximete Intervel Between Onset and Death Immediate Cause (Finel Neumonin disease or condition resulting in death) Physician/Medical Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Aves 2 No 1 ☐ Yes 2 No 8 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 Netural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

or Attanding Physician: The law requires that the death certificate be executed physician the burial Box 68760. signed by the a d be detached f Division of Vital Records, P.O. certificate this Atter within 24 hours after death. To the Funeral Director: A Hospital

Funeral

Director

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Pages 1 and 2 should be filed within 72 hours nent of Health and Merkal Hyglens. witt if Nem 27 is merked other than "netural", ary or other trainants event, the Medical Exp.

Physician /Medical

Examiner

burial-transit

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filled in by

filed within 72 hours after

Baltimore, Maryland 21215-0020

completely (Check only one) 8 29b. Signeture en

29a. Certifier

State Registrar

ww 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ORACE

title of certifier

IANO

32. Registrer's Signeture

125 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) and menner as stated.

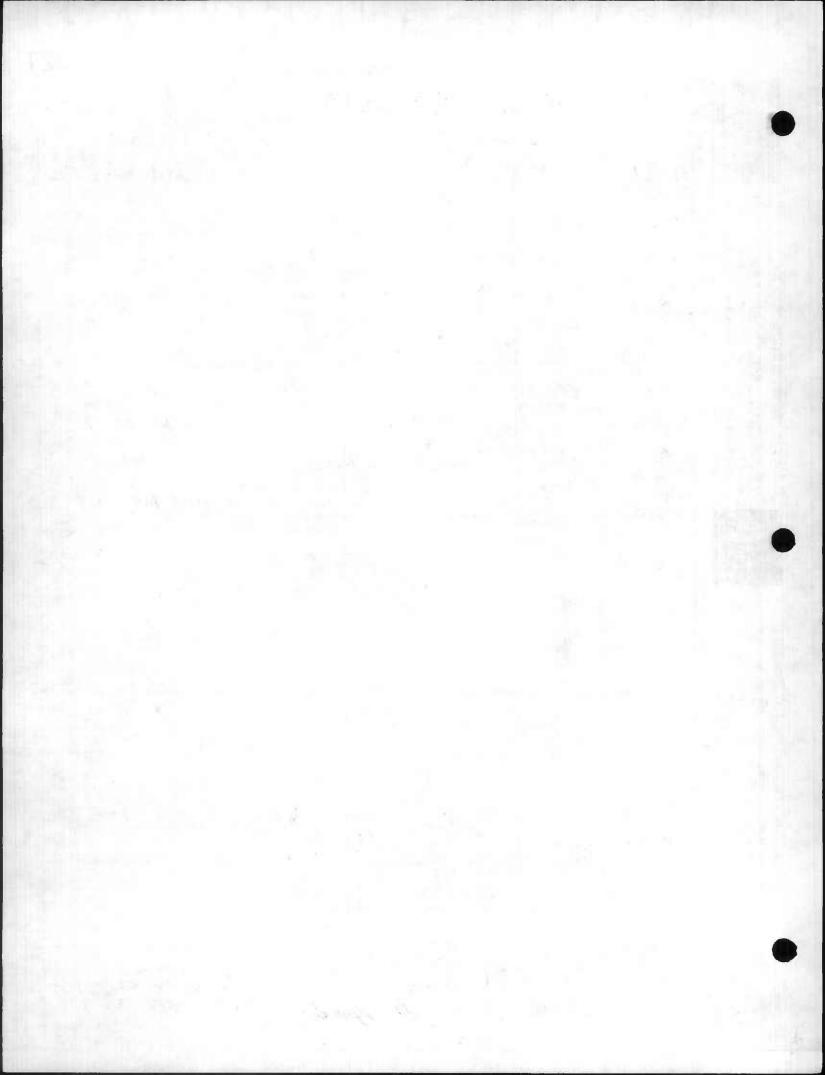
2 Medical Examiner; On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0035468 MARCH JOHNS INOPKINS ER.

29d. Date signed (Month, Day, Year)

600 North WOIFE ST Brottinore 21287



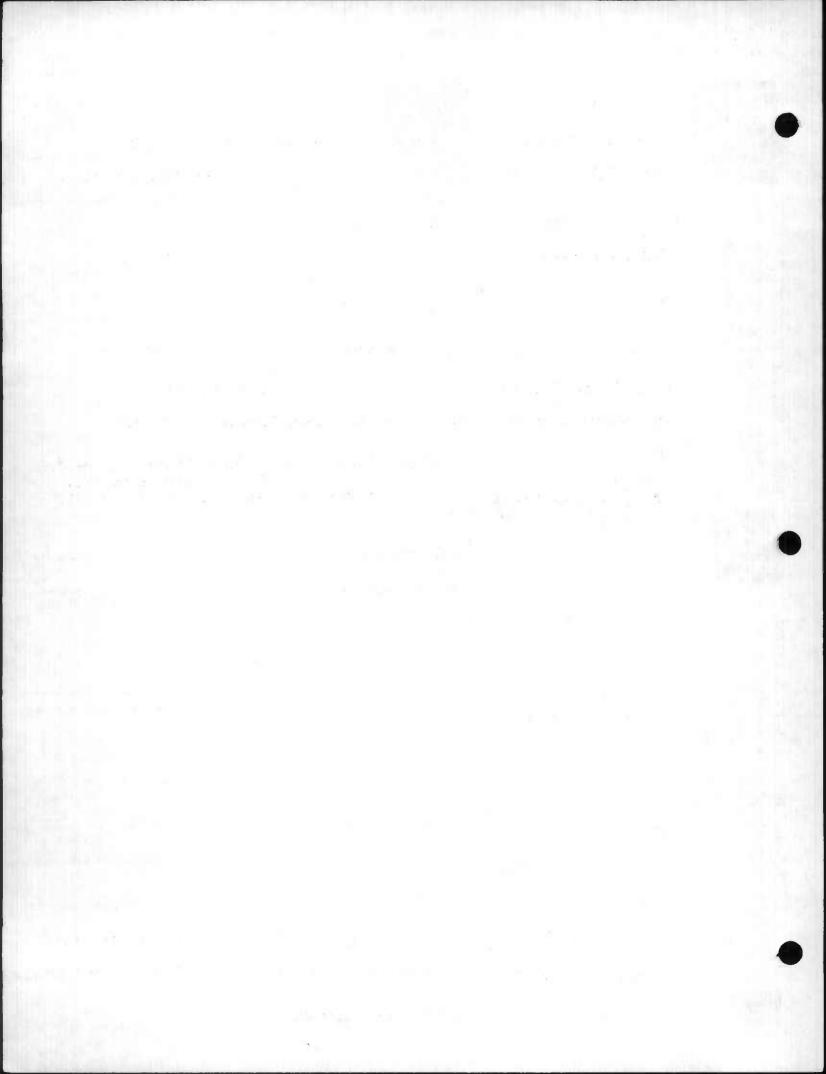
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Per No. 0 0 8928

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eral tor	146-30-441 Usuel Residence of Dece	1 '	M 2□XF	7. Age (In yr. 88		rs. Month				9, Year)		ece (Stete or Foreign ry) yland
eted by Funeral Director		County		10c. 0	City, Town	or Location					10	d. Inside City Limits
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edical	29e. Certifier 1 1 ℃ C (Check only 2 ☐ M	ertifying Ph adical Exan	ysician: To the bas end menne	sis of examir	nowledge, netion end	death occurre for Investigeti	ion, in my	time, dete end plece opinion, death occu	urred et the time,	date end pleca,	and due to	the cause(s)
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State of Maryland / Department of Health and Mental Hygiene 00 08929

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hysician /Medical		IRMA W. DOWNS	S								MARCH	14	2000	0943
xaminer	40	Facility Name (If not institution ST. AGNES HOS			n <i>ber)</i>				BAI	LTIM	ocation of Death ORE	- 100	of Death	
neral ector		ocial Security Number 212-16-6536	6. Se		7. Age (In yrs.	last birthday	Months	Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day 4-1	Year) 7-1919	9. Births	placa (State or Forentry) MD.
		at Residence of Decedent State 10b. Count	v		10c. Ci	ty. Town or L	ocation						- 1	10d. Inside City Lim
or and		MD. N/A			P	ALTIMO	דקר						1 Yes 2	
be notified	10e	. Street and Number				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10f. Zip C	ode				10g. Citizen of	What Cou	ntry?
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page 2											101	as 2 No	1	☐ Yes 2☐ No
director, pag	25.	Was case ralarred to medic examiner?	el						26. Place	of Deat	h (Check only o	ne)		
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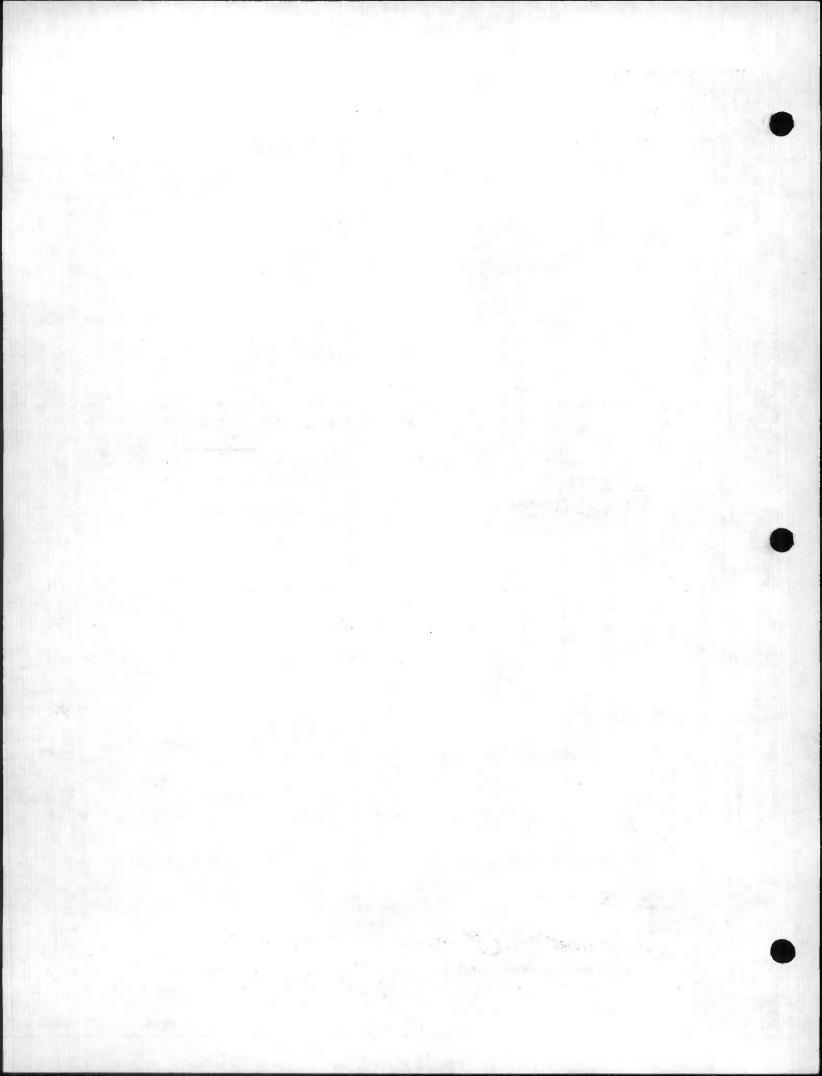
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death AMENDED ITEM #20b PER FH G781 3/20/2000 AH 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Time of Death Dey **Physician** Month Year MARCH 15, 8:40 am WILLIAM FITZHENRY, 2000 JR. /Medical 4e Fecility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GENESIS ELDER CARE SEVERNA PARK ANNE ARUNDEL 6. Sax 1 M 2 □ F If Under 1 Yaar 5. Social Security Number If Undar 24 Hrs. 7. Aga (In yrs. lest birthday) 8. Dete of Birth (Month, Day, Year) Birthplaca (State or Foreign Country) **Funeral** Days Months 203-12-6908 Hours 75 Director FEB. 6, 1925 PENNSYLVANIA Usual Rasidence of Dacedant 10a, Steta 10b. County 10c. City. Town or Location 10d. fnside City Limits 28a-f ahow Examiner must be notified at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL GLEN BURNIE 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 107 SHELLY ROAD Norms 23a 21061 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forcas? 112 Yas 2 □ No 19 If Yas, Giva 11. Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. 72 hours after 1 Navar Married 2 Married 1943 natural, or 1 ☐ Yes XXNo Specify: Specify: p WHITE 3 Widowed 4 Divorced Year or Dates: 1946 Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Businass/Industry Hygiene. PAINT Elementery/Secondary (0-12) Collega (1-4or 5+) CHEMICAL OPERATOR MANUFACTURING 12 17. Fathar's Nama (First, Middla, Last) 18 Mothar's Nama (First Middle, Maiden Sumama) Be 8 and Mentai WILLIAM FITZHENRY, SR. J. BRIDGET JOYCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Health F MRS. HELEN G. FITZHENRY (WIFE) 107 SHELLY ROAD, GLEN BURNIE, MARYLAND 21061 20b. Place of Disposition (Nama of cematary, crametory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 Burial 2 □ Cremation 3 □ Ramovel from Steta MEADOWRIDGE MEMORIAL PARK /20/2000 ELKRIDGE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Nama and Addrass of Facility SINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 tayou lions thet caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, pausa on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final diseasa or condition rasulting in daath) Examiner Examiner Sequentielly list conditions, if any, laading to immadiete causa. Enter Underlying Cause (Disaase or injury that initiated events resulting in death) Last and physician the burial Physician/Medicai schemic 88 Jav for use Part II. Other algoriticant conditions contributing to death but not resulting in the indertying cause given in Part I 23b. Did tobacco use contribute to the cause of death? 3 □ Probably 4 Unknown 1 Yes 2 No Completed by 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performed? livium de 1 ☐ Yes 2 ☐ No 25. Was casa referred to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: Other: Nursing Homa 5 Rasidence 6 Othar (Specify) 1 Yas 2 No Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Neturel 2 Accident Attending 5 Pending 1 ☐ Yas 2 ☐ No r death. Invastigation 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicide 6 29e. Cartifier

21215-0020 Baltimore, Maryland Box 68760, 0 ۵ Records. Division of Vital 24 hours after deaf Funeral Director: Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to tha causa(s) and manner as stated.

Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date and place, and due to tha cause(s) and manner stated. Medical tely (Check only one) To the To the To the To the 29d. Data signed (Month, Day, Year) 29c. Licanse numbe 3-15-00 79 Jun Severna Park MD ACIS Um 32. Ragistrar's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth **Physician** Month ()3 Theodore A. Fratta Sr. 2000 5:00AM. /Medical 4e. Fecility Neme (If not institution, giva street end number) 4h. City. Town, or Location of Deeth Examiner 4c. County of Deeth 303 South Highland Ave. Baltimore
If Under 1 Year | If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number 6. Sax 7. Age (in yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** 12 M 2 F Yrs. Director 212-26-7129 69 08/24/1930 MD Usuel Residence of Daceden the Marylend 10a. Stata 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumetic event, tra Medical Examiner ness be notified at 10d. Inside City Limits MD. Director 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 303 South Highland Ave. Funeral 21224 death USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American indian, Bleck, White, etc. 72 hours after 1 Yes 2 No 10/1951 If Yes, Give Year or Dates: 09/1953 1 □ Never Merriad 2 □ Merried Baltimore, Maryland 21215-0020 by Specify. 3 Widowed 4 Divorced 09/1953 White Completed 15. Decedent's Education (Specify only highast grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry pernit. Peges 1 end 2 should be filed within Department of Health and Mental thygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, tre Mes Elemantery/Secondary (0-12) College (1-4or 5+) Technician Security 12 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Teodoro Fratta Erminia Tosches 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Theodore A. Fratta Jr. 3723 Parkhurst Way Baltimore, MD. 21236 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) Dete 20c. Location - City or Town, State 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from State 03/16 Baltimore Washington Crem, 4 ☐ Donetlon 5 ☐ Other (Specify) Laurel, MD. 22. Name end Addrass of Fecility
Sterling Ashton Schwab Funeral Home, Inc. 21. Signature of Funeral Service Lio 736 Edmondson Ave. Baltimore, MD. 21228 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. **Physician** /Medical Immediete Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es e consequence of) Examiner thet the death certificete be executed pue Sequentially list conditions, if eny, leading to immediate cause. Enter Undarlying Ceuse (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or as e consequence of) P.O. Box 68760, attending physician for use es the burie Physician/Medical the Due to (or es e consequence of): Pert II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by the detached 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown signed to Records, by The law requires should should 24b. Were eutopsy findings evailable prior to completion of cause of deeth? 24e. Wes en eutopsy parformed? Be Completed page 2 s certificate 1 ☐ Yes 2 PNo 1 ☐ Yes 2 SHO Division of Vital Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica etely filled in by the funeral director, p 25. Wes case referred to medical exeminer? 26. Plece of Deeth (Check only one) Hospitel: Other: 4 ☐ Nursing Home 5 ☐ Nursing Home 6 ☐ Other (Specify) Certification: To 1 Yes 250No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 27. Menger of Deeth 28a. Dete of Injury (Month, Dey Year) 28h Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI completely filled in edical 29a. Certifier 🕊 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, and due to the ceuse(s) end menner es steted. (Check only one) 2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred at the time, date and piece, and due to the cause(s) end manner stated. 29b. Signature end titla of certifier 29c. License number 29d. Date signed (Month, Day, Year) 5-27921 man 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

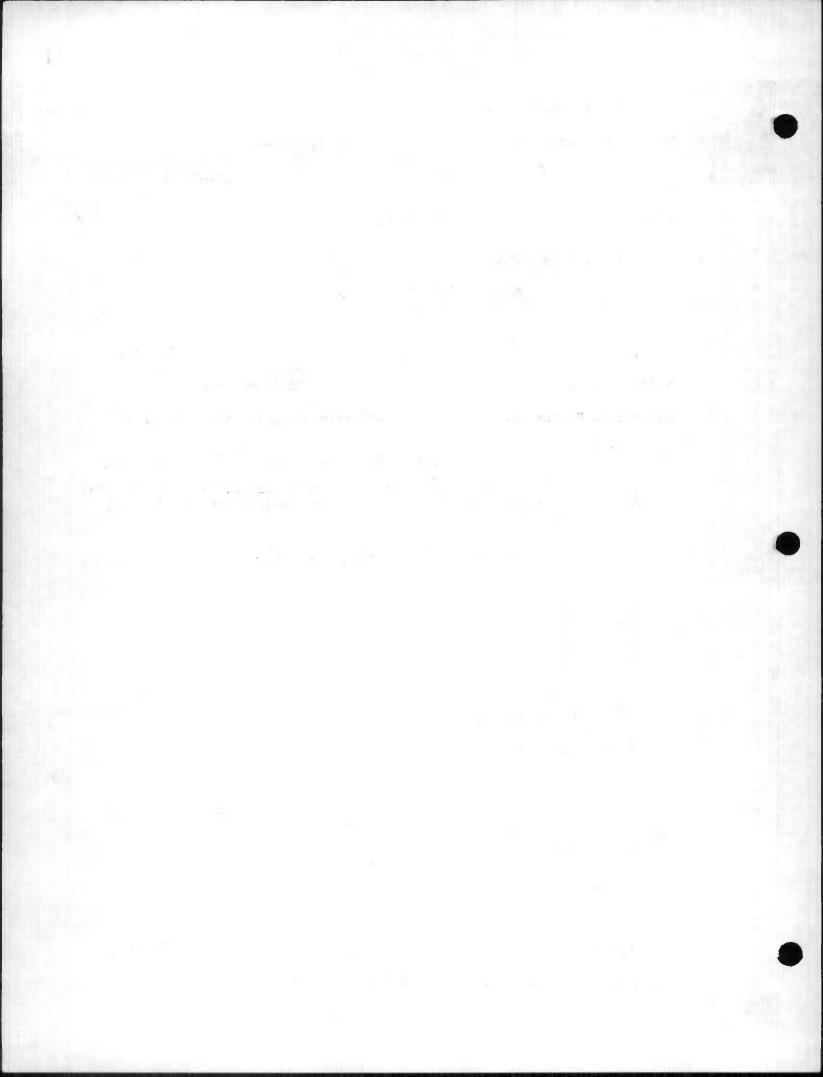
3411 Bank St. Baltimore, MD. 21224

32. Registrer's Signeture

DHMH 16 Ray 6/95

State Registrar

Melvin Welinsky 31. Dete filed (Month, Dey, Year) WAR 1 7



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death The (First, Middle, Last) 2. Date of Death Month Dey Year Month Dey Year

3. Time of Death 1. Decedent's Name (First, Middle, Last) MAR **Physician** EdwArd 25 16 2000 19600 Ames /Medical 4b. City, Town, or Location of Death cility Neme (If not institution, give street end number) 4c. County of Death Examiner Burnie Lourt 6/en Hollow Lot xulet 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5 Social Security Number Say 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** M 2□ F Months Days Hours Yrs. 36 216-74-7616 Director May 03 1963 Maryland Usuel Residence of Deceden the Marylend 10e Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 3 No Glen Burnie Director Anne Arundel Co. 10e. Street and Number 7891 Tall Pines Court 10f. Zip Code 10g. Citizen of What Country? "naturel", or items 23e or 21061 USA 7891 Tall Ines Court death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 14. Rece - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, Whife, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: white ð 3 ☐ Widowed 4 ☐ Divorced the Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Apartment Building Maintenance 8 0 7 is marked other traumatic event, i 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Mary A. Oettle Charles R. Hayes 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 7891 Tall Pines Court, Glen Burnie, Md. 21061 Health om 27 i Deborah Ann Hayes (Wife) Item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) = 5 permit. Page Department of Important: If any injury or 3/20/2000 Brooklyn Park, Md. Cedar Hill Cemetery 21. Signature of Feneral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest,

Approx. Approximete Interval Between Onsef end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) NSUSFICIENCY /Medical espirator minutes Examiner Due to (or es e consequence of): Examiner POXIA certificate be executed physician and s the burial-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Diseese or Injury fhet Initieled events resulting In death) Last Due to (or as e consequence of): Due to (or as a consequence of): reow Physician/Medical ettending pl signed by the e 23b. Did tobacco usa contributa to the cause of death? Pert II. Other elanificant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of ceuse of deeth? Completed 24a. Was an autopsy il director, page 2 s 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Ar King Lot examiner? 1 No 2 No Hospitel: 1 ☐ Inpetient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To this 28e. Date of Injury (Month, Day Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Attending 5 Pending Investigation 1 Naturel Luhaled GAS 15/00 1 Tes 2 To death. UNK 3 Director: A 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Community Parking Lot Glew Burnie, MD

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stafed. A 24 hour. the Funeral Direction 6 29a. Certifier Medical To the To the Complete 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) eputy

21035

and address of person who completed ceuse of death (Item 23a) (Type, Print)

2000 ▶

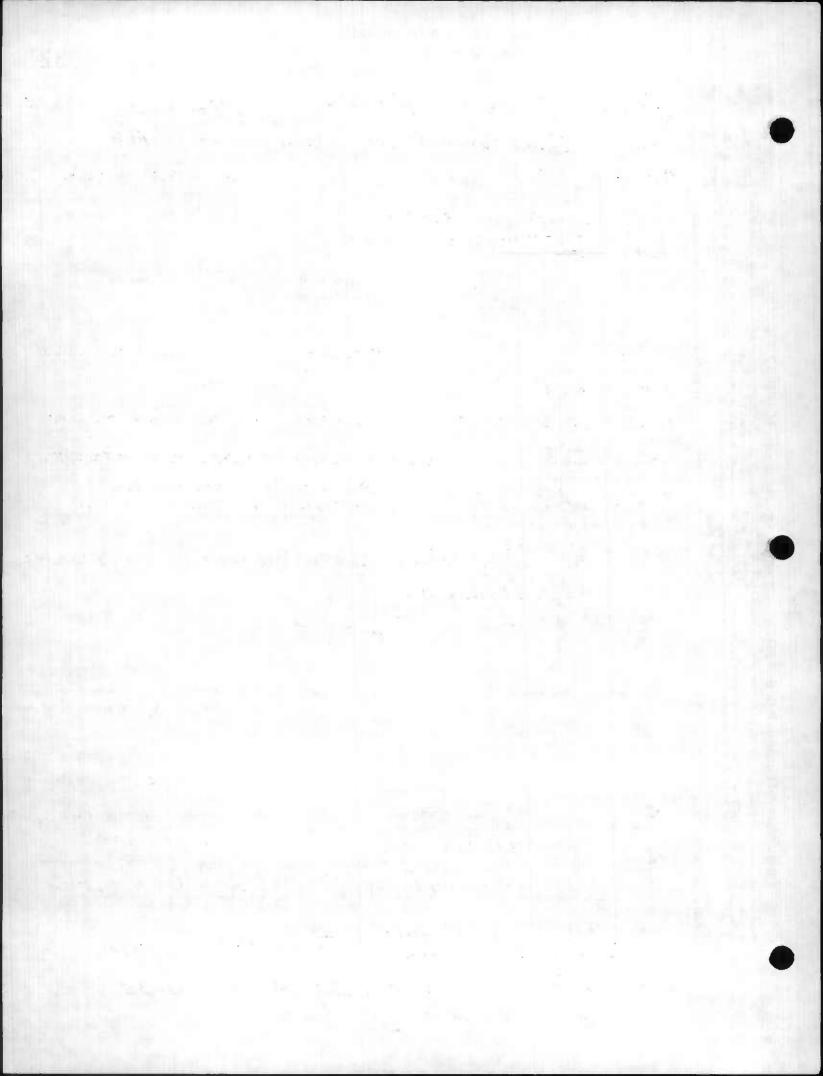
ONes.

AN O

32. Registrar Signature

State Registrar

31. Date filed (Month, Day, Year)



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Tima of Death Month Halbrook 1 ARCH 0630 am anet 12000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GEN BURNIE ARUNDEL HOSPITAL NORTH A 5. Social Security Number AACOUNT If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Months Devs Hours Min. (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) 10M 201 56 21242642 MARYLAND Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. fnside City Limits 1.1155801118 ACO 1-Tes 2 No 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 21108 () Mahir 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indien. 11. Merital Status Bleck, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Merried 2 Merried 1 Yes 2√ No Specify: Specify WHITE 3 Widowed 4 Divorced 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 N/A 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumama) **JAMES** HOLBROOK PAULINE DATSUN 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MARY ELLEN GRAHE (SISTER) 538 MILLSHIRE DRIVE, MILLERSVILLE, MARYLAND 21108 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20d 20a. Method of Disposition 20c. Location - City or Town, Stete 1 ☐ Burial 2 MCremetion 3 ☐ Removal from Stete CHESAPEAKE CREMATION CENTER, LLC 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD. 22. Name and Address of Fecility SINGLETON FUNERAL HOME, P.A., 21. Signatura of Funeral Senoce Licenses. 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest ne cause on each line. Approximate Intervel Between Onset and Deeth ulas Accident Immediete Cause (Finel 1 day disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did lobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No Mellitus 24b. Were autopsy findings available prior to 24a. Wes an autopsy parformed? completion of cause of death? 1 Yes 2 No 1 Tyes 2 No 26. Piece of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

10a. State

Examiner

Funeral

Director

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Pages 1 and 2 mportant: if liem 27

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Baltimore,

Box 68760.

P.0.

Records,

Division of Vitai

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must be notifie

Director

Funeral

by

Completed

88

physician and the burial-transit The law requires that the death certificate be assouted been signed by the attending should be detached for use as this certificate Attanding Physician: funeral director, After To the Hospital or Attandin within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fur

Examiner Physician/Medical þ Completed 8 Certification: To 27. Manner of Death 2 Accident 3 Suicide

Medical

25. Wes case referred to medical 1 Yes 2 No

> 5 Pending investigation 4 Homicide

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28c. Injury at Work? 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

1 Yes 2 No

28d. Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29b. Signeture end title of certifie

29a. Certifier (Check only one)

29c. License number

29d. Date signed (Month, Day, Year) 15 00

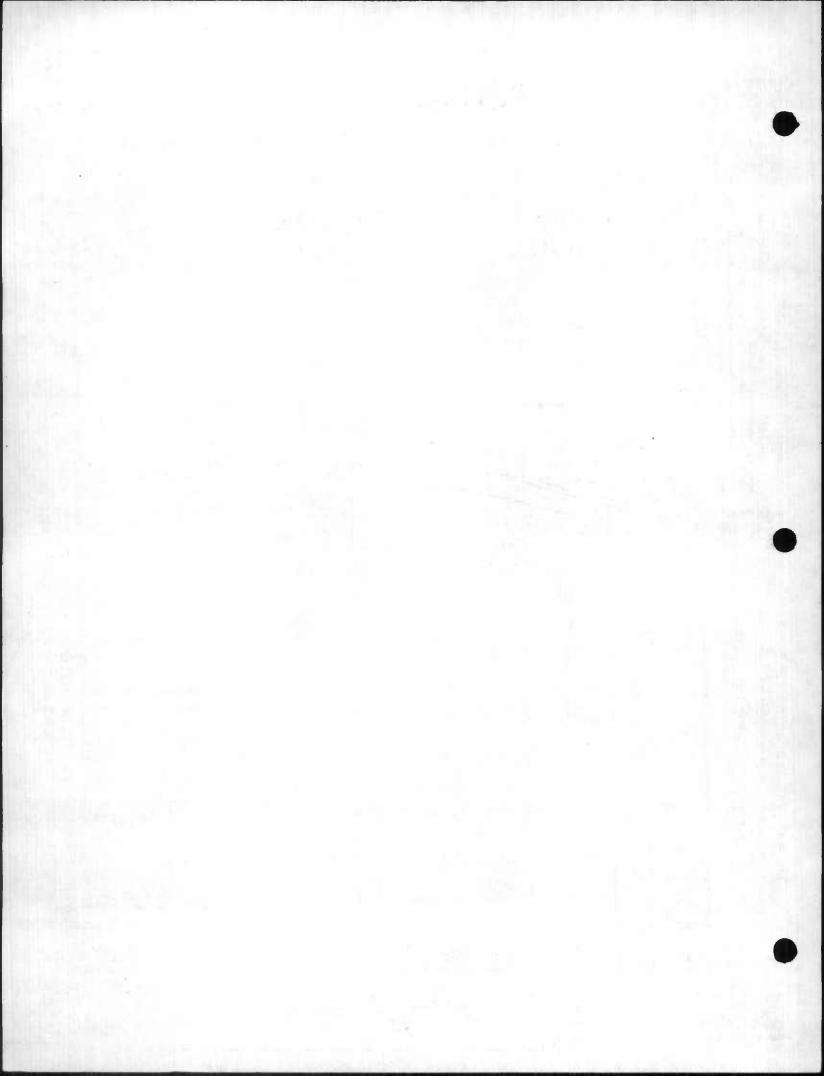
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sett 7711

ad 31. Dete filed (Month, Day, Year) MAR 1

32. Registrar's Signature 7 2000

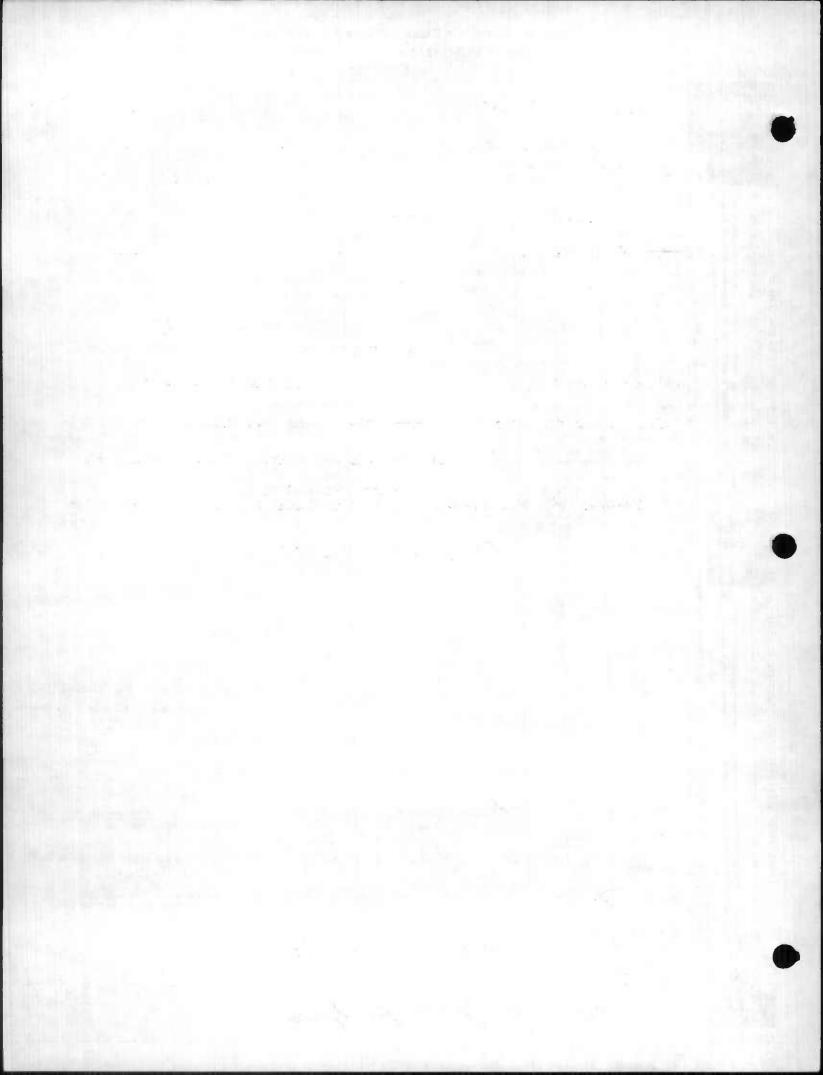
Quarterfield RD Glen Burnie MD 2,061 sacks

State Registrar



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ED THEMS #100	& #19b PER FH G781 3/		laryland	I / Departme				U	08	934		
Physician	1. Decedent's Neme (First, Middle, L		-/	Cortino	210 01	Douti	2. Dete of De Month	Day	Year 3.	Time of Deeth		
/Medical Examiner	4e Fecility Name (If not institution, g	and the same of the same					Location of Deet	4c. County	of Death	7		
Funeral Director	Montgomery Ge 5. Sociel Security Number 6. 220-58-9847		spita ge (In yrs. Ia 49		der 1 Year	Olney If Under 24 Ars Hours Min	. (Month, Da	th ly. Year)	Country)	(State or Foreign		
2	Usual Residence of Decedent			T			May 22	, 1950	Florid			
28a-1 show notitied at	10a. State 10b. County MD. Howard			Town or Location						nside City Limits ☐ Yes 2☐ No		
a rictitied	10e. Street and Number				Zip Code			10g. Citizen of V	Vhal Country?			
O les	6013 Golden Seed	s Row			044				S.A.			
by Funeral Director		12. Was Deceden Armed Forces 1 Yes 20 If Yes, Give Year or Dates:	? [No		cedent of h pecify Cub	dispanic Origin? (: an, Mexicen, Pue Specify:	Specify Yes or No rto Rican, etc.)	Blac	e - Americen in k, White, etc. : white	dien,		
Completed	15. Decedent's to (Specify only highest g Elementary/Secondary (0-12)		5+)	16e. Decedent's U (Give kind of life. DO NOT kinderga	work done Tuse retire	during most of wo d)	orking	16b. Kind of Bu		-		
To Be Cor	17. Father's Name (First, Middle, Las			rance ga	a cell	18. Mother's Na	me (First, Middle Jewell S	, Maiden Sumam				
ľ	19a. Informent's Name/Relationship			19b Mailing Address 7013						(e)		
	Alfred W. Hurley 20a. Method of Disposition 1 □ Burlel 2 🖫 Cremation 3	☐Removal from State	Cer	6013 Gol	Name of or other pla	ce)	Date	20c. Location -	City or Town,	Slate		
	4 Donation 5 Other (Specify) Baltimore/Washington Crem. 3/15/00 Laurel, 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility											
	I Shands 2	21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Witzke Funeral Home, Inc. 5555 Twin Knolls Rd., Columbia, Md. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dylng, such as cardiec or respiratory errest,										
ian ical ner	Immediete Cause (Final disease or condition resulting in death)	a.	Nal	es a consequence o	Co	incel			Feu	X .		
The second secon	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last	b		as a consequence of								
cian/		d										
by Physician/Medicai		contributing to death	but not result	ting in the underlyin	g ceuse gi	ven in Pert I.		Yee 2 No	atribute to the	ceuse of death?		
							24e. Was	en eutopsy ormed?	availab	utopsy findings le prior to tion of cause h?		
Completed							10	Yes 20 No	1 ☐ Ye	s 2/2/No		
Be C	25. Was case referred to medical examiner?	Hospital	inat 005	R/Outpatient 3□	DOA Ot	hor	eath (Check only		or (Conside)			
hysle on his on							g Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred					
Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 289. Place of II	njury - At hon etc. (Specify)	ne, farm, street, fac	tory, office		28f. Location City or To	(Street and Numb wn, State)	per or Rural Ro	ute Number,		
completely filled in by Medical Certifi	29a. Certifier (Check only one) 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es ateled. 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.											
5	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									Year)		
Nº -	30. Name and address of person who	o completed ceuse of	deeth (Item	23a) (Type, Print)	1000	Phi	170 M	0/1	7,00	7190		
State	31. Date filed (Month, Day, Year)	7 2000 32 Regis	trat's Signetu	ire &	1		4 01		/ 1	0 (1 0)		



						Ce	rtificate	of L	Death			Reg. No.			
		1. Decedent's Na	me (First, Middle, L	ast)							2. Dete of De Month	eath Day	Year	3. Time of Deeth	
	Physician /Medical	SARAH	MARGARET	ISELIN							MARCH		000	11:35	AM
	Examiner	4a Facility Name	(If not institution, g	ive street and numb	ner)			41	b. City, To	wn, or Lo	cation of Deal	h 4c. County	of Death		
				RAN VILLA					HAGE				INGT	ON	
	Funeral :	5. Social Security 215-20-7	Contract of the Contract of th	Sex 1 □ M 2 ☑ F	Age (In yrs. las	6 Yrs.	Months I	Year Days	Hours	Min.	8. Data of Bir (Month, Da December	IV Year)	9. Birth	place (State or Foreign A	gn
Pu	*	Usual Residence	of Decedent 10b. County		10c. City.	Town or L	ocation							10d. Inside City Limit	e
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-	or 28e-4 a be notified Director	10e. Street and N	1	gcon	DIE	1001	10f. Zip C	ode		-		10g. Citizen of \	Whet Cou		
WIE	23a or	12635 P	ecktonvi	11e Road			2171					USA			
) frer deeth with the Maryland	lems of the second	11. Marital Status		12. Wes Decede Armed Force 1 Yes 2	85?	13.		nt of His	n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	- 14. Rac	ce - Ameri ck, White,	can Indian, etc.	
020	by F		4 Divorced	If Yes, Give Year or Date	• •		1□ Yes 2)	No	Specify:		Specify:			nite	
2 2 2	ted bet	(0)	15. Decedent's			16a. Dece	dent's Usual of work	Occupa	ition	of work	16b. Kind of Busine				
11215-0020 within 72 hours after	Completed	Elementary/Sec	condary (0-12)	College (1-4	or 5+)	tife.	DO NOT use	retired)	uring most	OF WORK	orking				
d 21	CO	12	we disways			Home	emaker			2000	Own Home				
DUE ST	2 ahouid be end Mental la marked o eumatic event la marked o TO Be		17. Father's Name (First, Middle, Last) Harry Carl Sampson										t, Middle, Maiden Sumame)		
Tyle May		-	-		Ruth Ann Metz							m State 7in Code			
Ma		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Judy Ann Dickey/Daughter 12.635 Pecktonville Road Big Pool MD 2.													
0 - 1		Judy Ann Dickey/Daughter 12635 Pecktonville Road Big Pool, MD 21711 20a. Method of Disposition 20b. Place of Disposition (Name of Competent, crematory of other place) 20c. Location - City or Town													
altimore, Maryland 21215-0020	100		Cremetion 3 5 Other (Spec	Removel from Sta	ate	,	Cemete		9)	2/	15/2000	Big Poo	1 M	0 21711	
B H	125		uneral Service Co	- 11	µ CLIC		2. Name and COVE FI		s of Facilit			DIE 100	19 11	0 21/11	
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		23a. Part1. Enter	the disease, or co	riprosurtorio shat cat	sed the death.	ath. Do not enter the mode of dying, such as cardiac or raspir						errast,	1	Approximata Interval Between	
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	ledical	Immediate Cause disease or condit	ion	. Toft w	entricu	ricular dysfunction					29 Cills		. (ONE MONTH	
EX	aminer	resulting in death)	a. Leit v	Due to (or a				/11				1	ONE MONTH	
2	i i			, Hypert	ensive	card:	iovascı	ılar	dis	ease			1	MANY YEARS	5
Sout	sician and burlatranak bal Examiner	Sequentially list of any, leading to cause. Enter Unc	conditions,		Due to (or a	s a conse	quence of):								
609		cause. Enter Unc Cause (Disease of that initiated even	OL HUMANA	c									i		
ontificate be assect	£ 5	resulting in death			Due to (or a	s a consec	quence of):						1		
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Geeth	d for use	Part II. Other elem	ificent conditions	contributing to deat	h hud met enculti	na in tha s	endorbring on	una minus	n in Dart I		23h Did	tobacco use co	ntribute t	o the cause of deat	h 2
Og	by the											Yes 2□ No	3 Pro		
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of Vital Records, Physicien: The lew requires the	been sign should be eted by	aphasia	eakness	ess					24a. Wes en eutopsy performed?			Vere autopsy findings veilable prior to empletion of cause I death?	S		
B. B.	page 2			1 Yes 2 No 1 Yes 2 No											
Vital	rector, par Be Co	25. Was case refe	erred to medical			26. Place of Death (Check only one)									
yalo <	0 D	examiner?	(No	Hospital: 1 Inp	nationt 2 E	VOutpatie	nt 3 DOA	Othe				idence 6 Oth	ner (Speci	ify)	
	63	27. Manner of Dea	ath 5 Pending	28a. Date of (Month,		8b. Time o		c. Injury Work		-		how injury occur			
Vision	by the funer tiffcation:	2 Accident	investigati	on		M 1 Yes 2 No									
V	tiffic	3 ☐ Suicide 4 ☐ Homicide	6 Could not detarmine	d 200. Place of	Injury - At hom	e, farm, st	reet, fectory,	office			28f. Location (City or To	Street and Numi	ber or Rui	ral Route Number,	

ISELIN, Sarah Margaret

State Registrar

29a. Certifier (Check only one)

29b. Signature and title of confidence

Edson Moody, MD

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1190 Mt. Aetna Rd., Hagerstown, MD

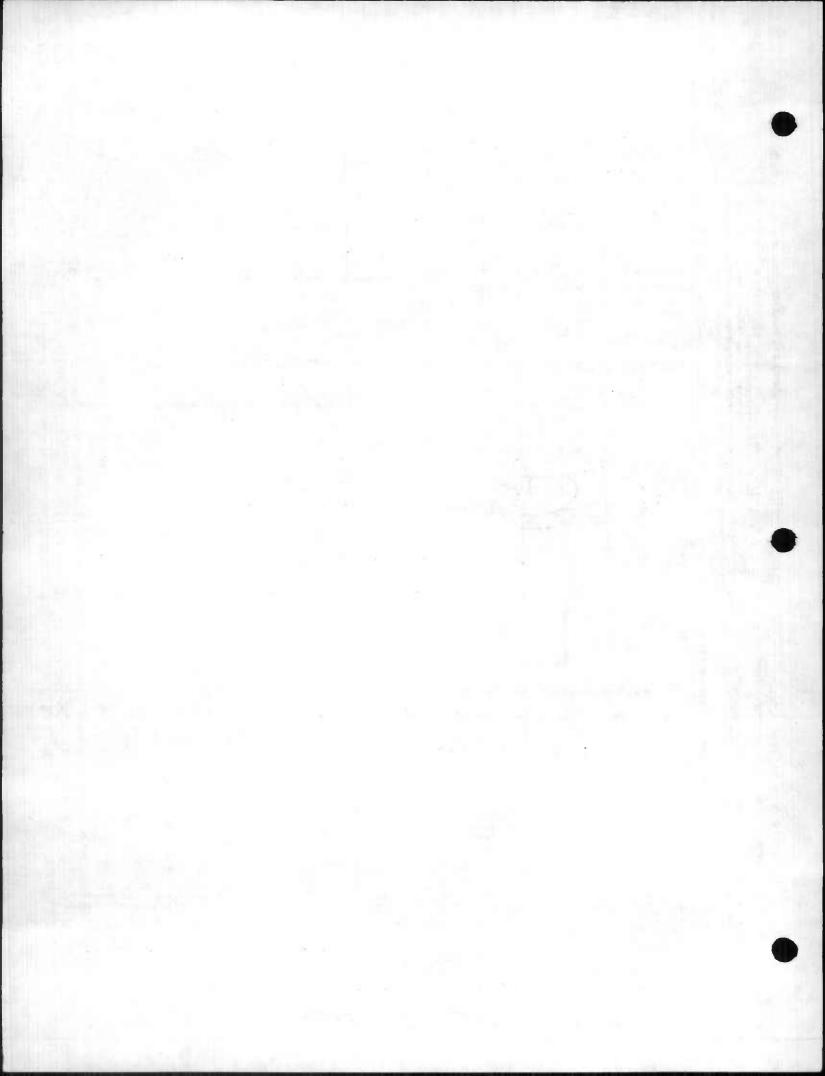
Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the tima, data and place, end dua to the ceuse(s) and manner stated. 29c. License number

D07857

29d. Date signed (Month, Day, Year)

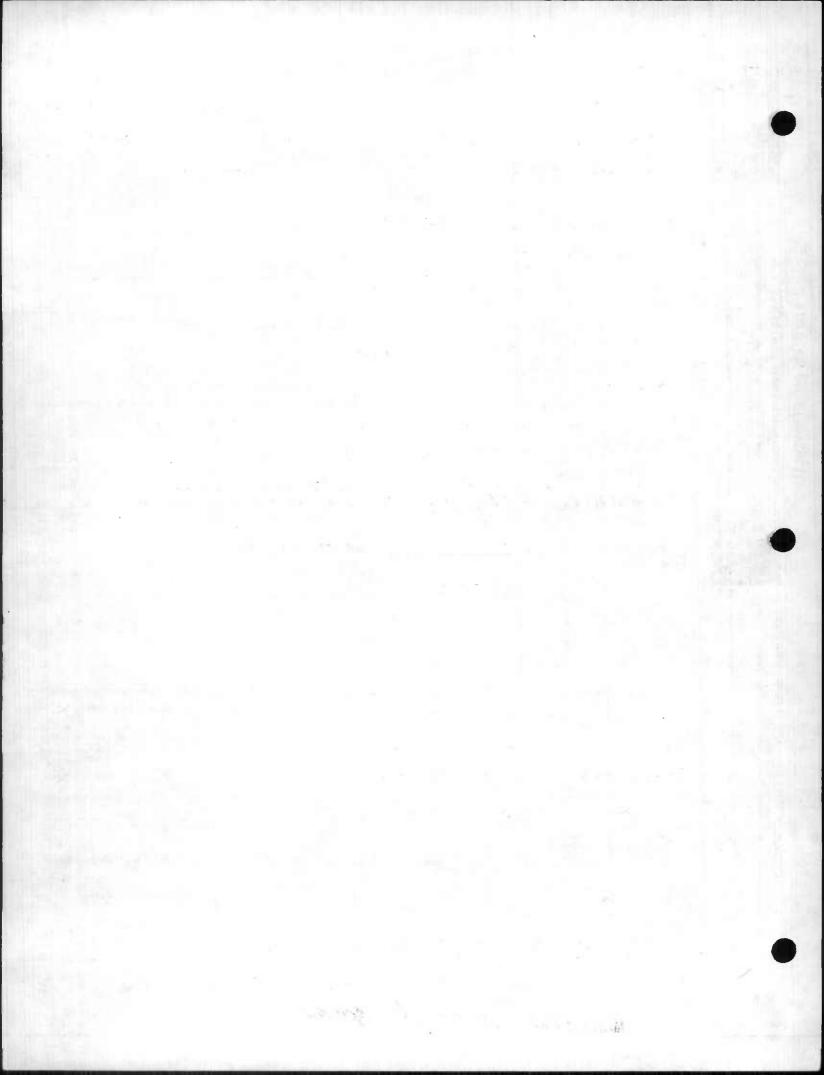
MARCH 13, 2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMENDED ITEM #23a	PER MD 6781 37	16/2000 /		of Marylan		partment of ertificate			Mental H	ygiene ()	0	08936	
	Decedent's Name (2. Date of D	eath	Vans	3. Tima of Death						
Physician /Medical	Beryl Jer	ome							Month	5. 20	Year	0530	
Examiner	4a Facility Name (If n						4b. 0		ocation of Dea				
	PENINSUI 5. Social Security Num		ONAL MEI	7. Age (In yrs.		v) If Under 1 Y	ear If	SALISI Under 24 Hrs.			COMI		
Funeral Director	578-48-05 Usual Residence of D	75	1 M 2 F	87	Yrs.			lours Min.	8. Date of B (Month, D May 20	S, 1912	Mary	place (State or Foreign http) Land	
M wand		0b. County		10c. Cit	y, Town or I	Location						10d. Inside City Limita	
C 40 ml	MD	Wicomic	0	s	alisb	urv						1 ☐ Yes XX No	
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20 ₹ 8 8 E	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town 19c. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town 1423 Dogwood Lane, Bellehaven, VA 2												
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of Vital Records, P.O. Box 68 Physician: The law requires that the death certificate has been signed by the attending plotal director, page 2 should be detached for use as it. To Be Completed by Physician/Mec	Conesa	OURS	cur	R Ac	- C10	ENT				s en eutopsy formed?	an	fera autopsy findings vailable prior to	
Vital Relations The law conflicate has rector, page 2										□ Yes 20 No			
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Division of Vital Re To the Hospital or Attending Physician: The lawin 124 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com	29e. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated. 2 Medical Employer. On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
To the within To the comp													
\	30. Name and address to person who completed cause of death (Item 23a) (Type, Print) Dr. David Sectler 145 E. Carroll Street, Salisbury Md 21801												
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 7 2000 32. Registrar's Signature \$\int_{\text{Density}} \int_{\text{Density}} \int_{												

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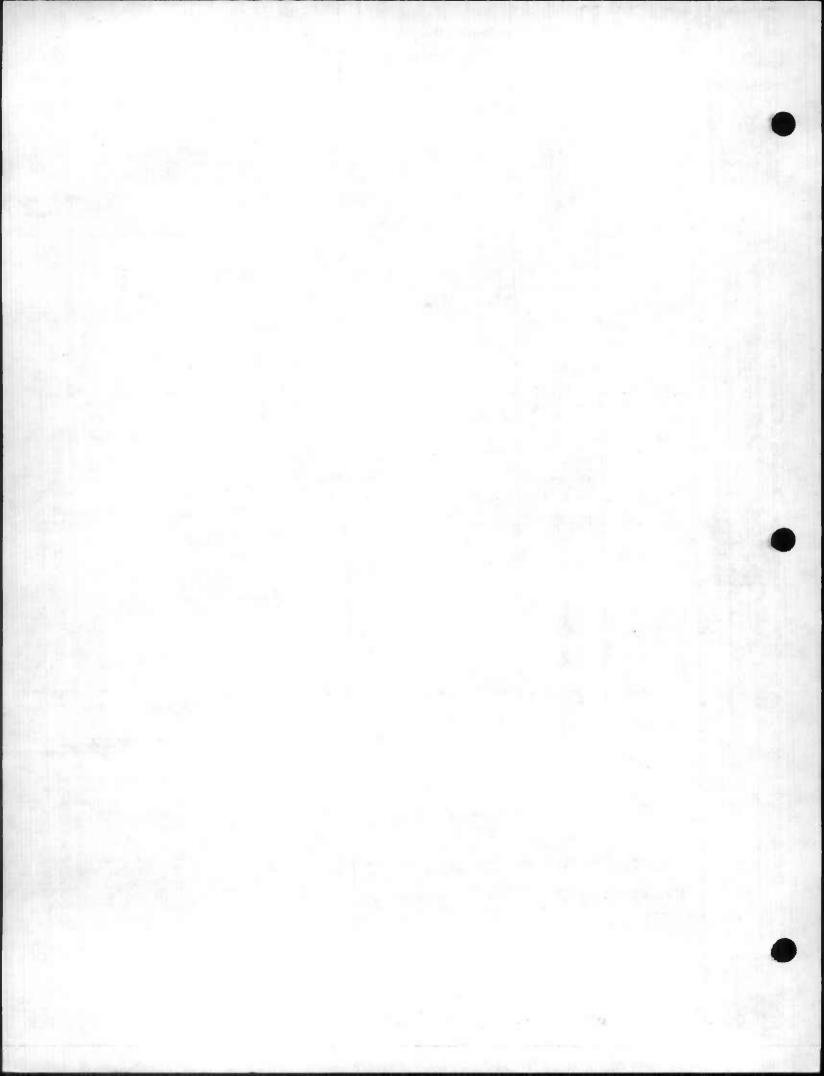


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State of Maryland / Department of Health and Mental Hygiene [] []

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Director	Usual Residence of Decedent	87				Oct. 3,	1912		Pa.	
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Asy Asy	ō		74						1 ☐ Yes 2 ☑ No	
or 28a-f show be notified at	Md. Baltim 10e. Street and Number	ore (Glen Arı	10f. Zip Code			On Chinan of I	After Course	-0	
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a sale		1 ☐ Yes 2 🖄 No If Yes, Give	1	☐ Yes 2 No	Specify:		Specify	Specify:		
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and	Mrs. Lynlee I. Br			ndy Hill	Rd. Gle	en Arm, N				
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the second										
v require been si should	8					24a. Was a			re autopsy findings ellable prior to	
aw re									mpletion of cause death?	
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ding h. Afte	1 Neturel 5 Pending investigation	(Month, Day Year)	Injury	28c. Injur Wor	k? Yes 2 □ No		,,			
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or A Direction by	Suicide 4 Homicide 28e. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, Stete)									
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(1)	30. Neme and address of person who o	completed cause of death (Iter	n 23a) (Type, F	Print)	00-0	. 0	11.	100	201007	
10	MICHELLE BOSI	WELL 7000	trank	111 260	gre ur	ive 18a	1tim or	e m	Da1837	
State	31. Date filed (Month, Dey, Year)	32. Registrars Signa		4 1	11					
Registra	dean a re	anno Dense	par 1	J. Ann	UKA!					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. AMEND ITEM: #5 PER F.H. G789 3-17-2000 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month 737 PM CARLOS KING JR 2 2000 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death HOSPITAL BALTIMORE
If Under 1 Year If Under 24 Hrs. 8. Date of B BALTIMORE -174 BALTIMORE VETERANS AFFAIRS 5. Social Security Number 326-42-6808 366-42-6808 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Deys 1X M 2□ F Yrs. 50 ILLINOIS Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits X⊠Yes 2 No BALTIMORE CITY MARYLAND N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21217 2449 McCulloh Street 14. Rece - American Indien. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Marital Stetus Black, White, etc. 1 KiXas 2 □ No If Yes, Give Year or Dates: 66/69 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Novorced 16a. Decedant's Usual Occupation (Give kind of work done during most of working lite. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elamentary/Secondary (0-12) College (1-4or 5+) 12th grade DISABLED N/A 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) INDIANA BROWN CARLOS DEVICE ROMEO KING SR 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaVerne M. King/Ex-Wife 405 Benton Woods Lane, Reisterstown, MD., 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1XX uriel 2 Cremetion 3 Removal from State GARRISON FOREST 3-20-00 OWINGS MILLS, MARYLAND 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral S 22. Name and Address of Fecility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA Kollle 1206 W NORTH AVENUE 23a Partt Emer the Wiense, or complications that caused the death. Do not enter the mode of dying, such es cerdiac or raspiratory arrast, shock de bean failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting In death) SEPSIG 4 WEEKS PNEUMONIA Due to (or as e consequence of): Sequentially list conditions, if any, laading to immediate causa. Entar Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): 23b. Dfd tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of daath? 24a. Was an autopsy 1 Yes 2 No 2 No 1 ☐ Yes 25. Wes case referred to medical exeminer? 26. Place of Daath (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1X Inpatient 2 □ ER/Outpatient 3 □ DOA 28d. Dascribe how injury occurred 27. Manner of Daath 28b. Time of 28c. Injury at Work?

Physician /Medical Examiner

Examiner

Physician/Medical

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Certification:

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29a. Certifier

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permit. Pages Department of Important: If it eny Injury or o

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Pages 1 and 2 should be filed within 72 hours efter death nent of Health and Mental Hygiene.

wit: If them 27 Is marked other than "naturel", or theme 23 mry or other traumatic event, the Wed on Examine must you other traumatic event, the Wed on Examine must

with the Maryland

physician and the bunal-transit the death certificate be executed 98 950 signed by the a been si s certificate has b or Attending Physician: director. this funeral deeth. by the f

Division of Vital Records. P.O. Box 68760.

1 Naturel 2□ Accident 3 ☐ Suicide 4 ☐ Homicida

5 Pending investigation 6 Could not be determined

28a. Date of Injury (Month, Day Year)

1 Yes 2 No

28e. Place of Injury - At home, farm, street, fectory, office building, atc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

🔀 Certifying Physicfan: To tha best of my knowledga, daath occurred at tha tima, date and place, and due to the causa(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and titla of contifier

Kuo MO

29c. License number

29d. Dete signed (Month, Day, Year)

30. Name and address of person who complated causa of daath (Itam 23a) (Type, Print)

STREET, BALTIMORE, MO 32 SOUTH GREENE WILBUR KUD 31. Date filed (Month, Day, Year)

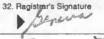
State Registrar

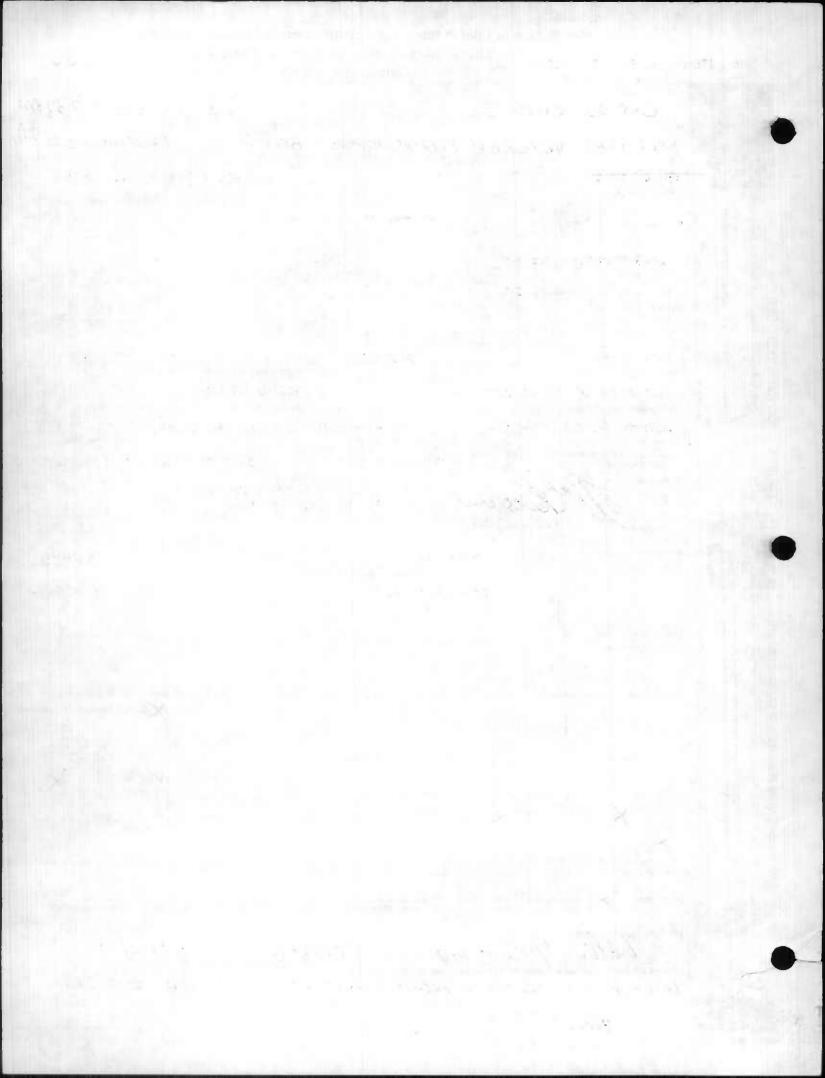
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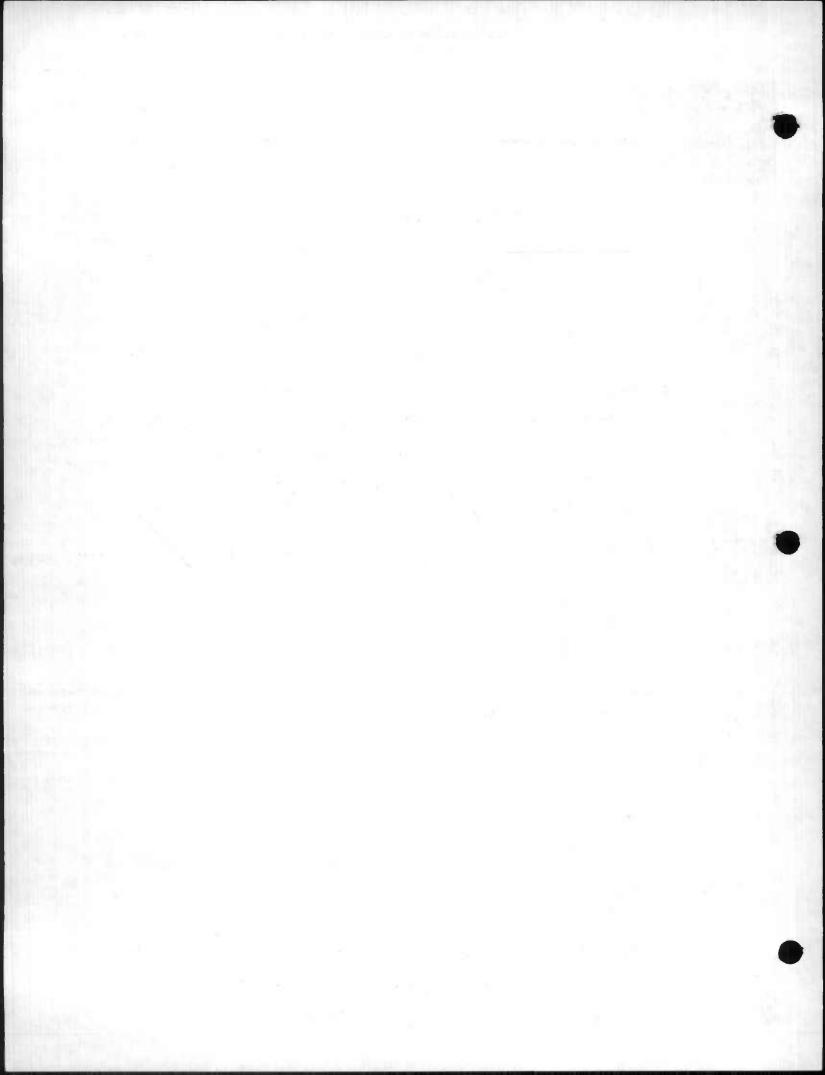
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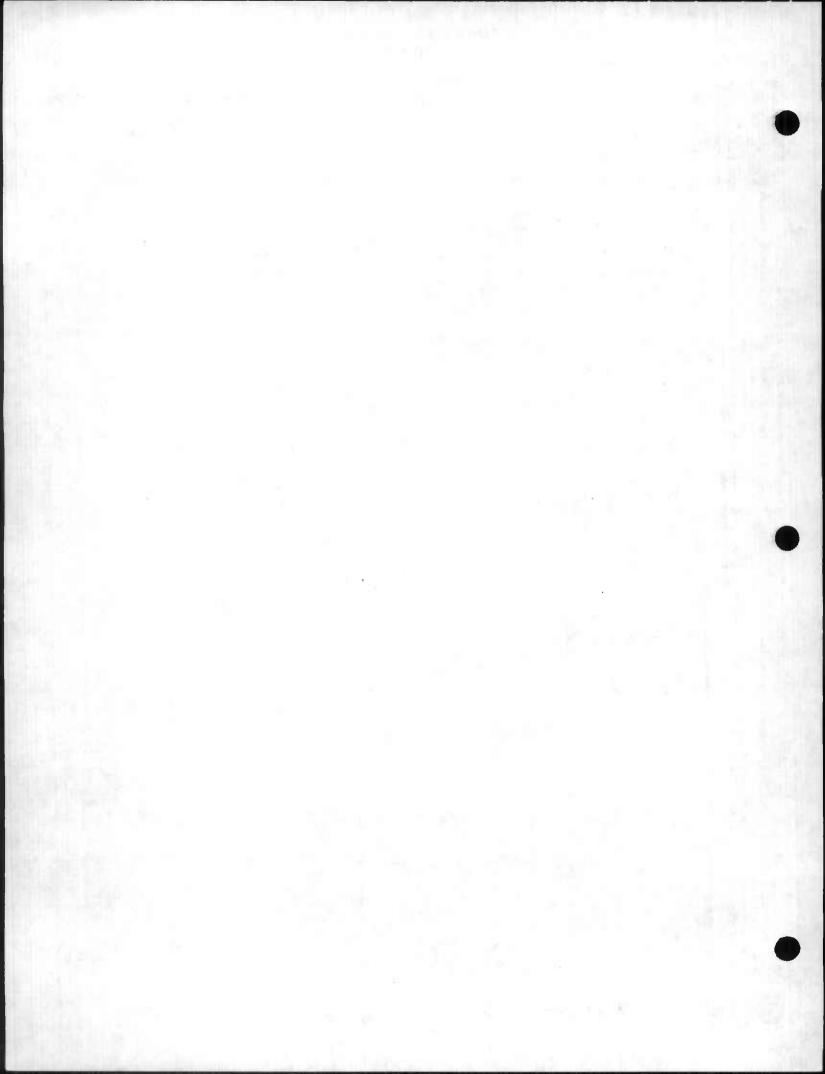
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State of Maryland / Department of Health and Mental Hygiene

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				Cei	rtificate o	Deam		Reg. No.				
ician dical	1. Decedent's Name (First, Midd MARTIN	fle, Last)		KALN	IAR		2. Dete of D		OGar	3. Time of Death 7:30PM		
niner	4a Facility Neme (If not institution ST. JOSEPH	on, give street and r HOSPIT				4b. City, To	wn, or Location of Dee N		IMORE			
al or	5. Social Security Number 386–50–7824	6. Sex 1 M 2 □ F		. last birthday) Yrs.	If Under 1 Yes		24 Hrs. 8. Dete of 8 (Month D) MAY 15	1947	9. Birthp	lece (State or Forei		
	Usual Residence of Decedent 10a. Stete 10b. Count	,	100 0	ity, Town or Lo	cation				1	Od. Inside City Limit		
Director	MD BALTI		1.00	TIMORE						1□Yas 2√N		
I Dire	10e. Street and Number 3308 MARNAT RC	AD			10f. Zip Code 21208			10g. Citizen of V U.S	Whet Country?			
by runeral	11. Merital Status 1 Never Merried 2 Me 3 Widowed 4 Divorce	rried 1 Tyes	ecedent Ever in I Forces? s 2 No Give		Was Decedent of the Yes, specify Control of Yes 2 No.		gin? (Specify Yes or N , Puerto Rican, etc.)	o- 14. Rac Ble Specify	e - Americ ck, White, v: WH]	etc.		
		nt's Educetion	Detes:	16e Dece	dent's Usuel Occ	unation		16b. Kind of Business/Industry				
	(Specify only high Elementery/Secondary (0-12)	est grede complete	d) (1-4or 5+)	(Give	kind of work dor DO NOT use reti EGE PROF	ne during mosi ired)	t of working	FREDERI	CK CC	OMMUNITY		
				COPPI	EGE PROF		45.	COLLEGE				
	17. Fether's Neme (First, Middle JOSEPH	, Last)	KALMA	ıR		MIRI	er's Name (First, Middl AM		CHLAI	NGER		
lury or other trac	19e. Informant's Neme/Reletionship (Type, Print) DEBORAH KALMAR/WIFE 19b. Meiling Address (Street and Number or Rurel Route Number, 0 3308 MARNAT ROAD BALTIMORE, MD.											
	20e. Method of Disposition 20b. Place of Disposition (Name of 1 Series) 20c. Location - City or 1 Series (Computer Cremator) of other Disposition (Name of 2 Series Cremator) of other Disposition (Name of 3 Series Cremator) of other Disposition (Name of 2 Series Cremator) of other											
	21. Signeture of Funerel Service Licensee 22. Name end Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD.21208											
VMedical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that Intileted events resulting in death) Last	b. <u> </u>	Due to	(or es e consector es e consec	quence of):	Dire	ase.					
Physician	Part II. Other significant condit	ions contributing to	deeth but not re	sulting in the u	nderlying cause	given in Pert I		d tobacco use co		o the cause of deat		
Completed by P							24e. We	es en autopsy formed?	ev	era autopsy finding ailable prior to		
						7. 11	15	Yes 20 No	of	mpletion of cause death?		
De C	25. Wes case referred to medic	at				26 Place	of Deeth (Check only		1	J 163 20 110		
)	examiner? 1 ☐ Yes 2 Ø No	Hospitel:	Inpatient 2	ER/Outpatie	nt 3 DOA	Other:			ner (Speci	(v)		
							28d. Describ	Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred				
27. Menner of Deeth 1 Neturel 2 Accident 3 Sulcide 4 Homicide 28b. Dele of Injury (Month, Dey Year) 28b. Time of Injury M 28c. Injury et Notr? 1 Yes 2 No 28c. Injury et Notr? 1 Yes 2 No 28d. Describe now injury occurred									el Route Number,			
29a. Certifier 29a. Certifier (Check only one) 29b. Signatures and title of certifier 29c. License number 29c. License number 29c. License number 29d. Date signed (Month, Day, Year)												
Me	29b. Signature and title of centifier 29c. License number D 29c. License number D 29d. Date signed (Month, Day, Year) Nate L 17 2000											
	30. Name and address of person	William Sorrpleted on	is of deeth (It	om 23a) (Type	8600 (Both	y Robad	· Back	matt	2/33		
	31. Date filed (Month, Day, Yea	32.	. Registrer's Sign	neture			1	1				

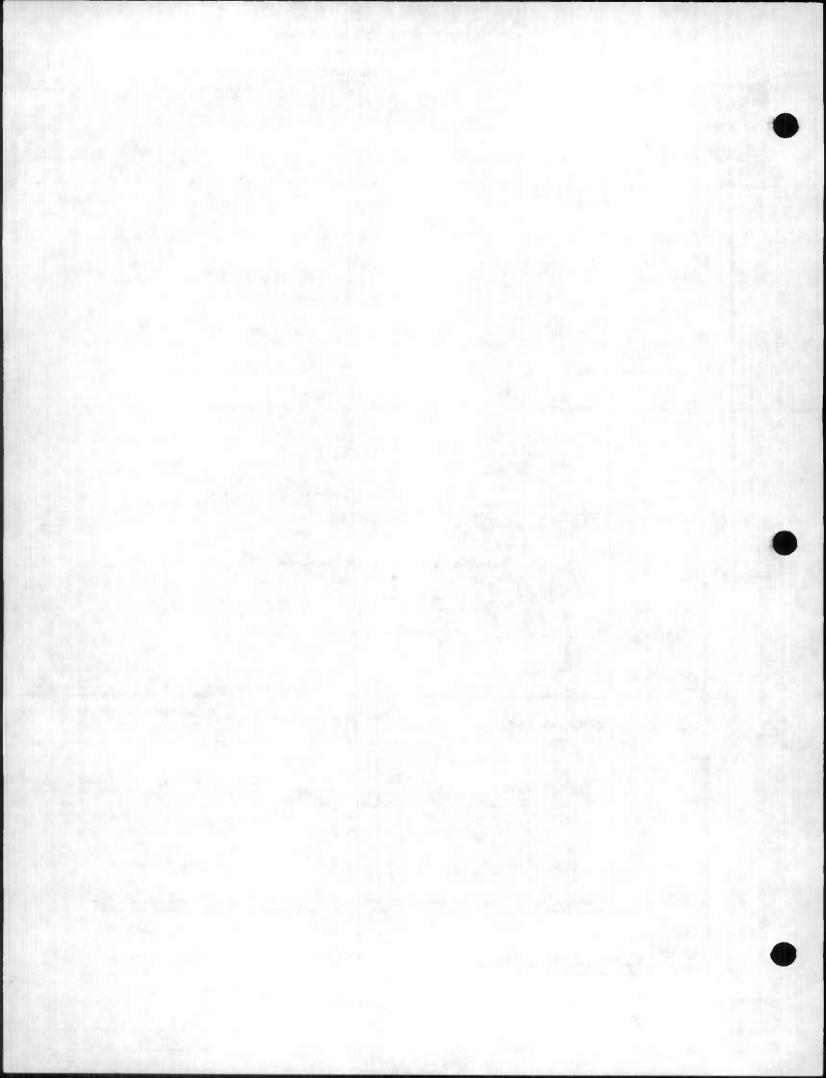
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State of Maryland / Department of Health and Mental Hygiene 00 001.

	Decedent's Na	me (First, Middle, Last)			Cer	tifica	te of	Death	2. Date of De	Reg. No.		3. Time of Death	
Physician		t Gertrude Lo							Month March 14	Day 2000	Year	1:15 pm	
/Medical	-	(If not institution, give s	-	r)				4b. City, Town, or			of Deeth	ווידי הוו	
Examiner	126 E. Pa							Timonium		Baltim			
Funeral	5. Social Security		7. 4	iga (In yrs.	last birthday)		r 1 Yaar	If Under 24 Hrs				place (State or Foreign	
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Man Hed fled	MD	Baltimore		Tim	mium							1 ☐ Yas 2 No	
or 28ef a be notified	10e. Street and N	umber				10f. Z	p Code			10g. Citizen of V	Vhat Cou	ntry?	
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har death with the Maryla r Name 23s or 28e-f sho shar must be notified at Funeral Director	11. Marital Statua		2. Was Decedar	t Ever in U	S. 13. V			dispanic Origin? (5	? (Specify Yes or No- uerto Rican, etc.) 14. Race - American Indian Black, White, etc.				
3 22 2		mied 2 Married 4 Divorced	Armed Forces 1 Yes 2 If Yes, Give Year or Datas] No	1.0	i Tas, sp I □ Yes		Specify:	to rican, etc.)	Specify		ite	
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y sa build to Manual mile a file a	William	William Boswell 9a. Informant's Name/Relationship (Type, Print)					Margaret Bownan						
2 shot and			oe, Print)		-		end Number or R			Stete, Zip	o Code)		
C 1 0 F	Bill Low		1000		126 E			Rd Timor	rium, MD 2				
mit. Pages 1 a partment of Hes portaint if Item y Injury or other SB.	1 Durial 2	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetary or other place) 20c. Location - City or cemetery, cremetary or other place)										own, State	
permit. Departmingorta Importa any inju	21. Signeture of F	21. Signeture of Funeral Service Licensee 22. Name and Address of Facility CAFA Stephen D. Lohrmann, P.A.											
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. 0 0 0	Pert II, Other sign	ificant conditions con	Inbuting to death	but not res	ulting in the u	nderlying	cause gi	ven in Part I.	23b. Dld	l tobacco use co	ntribute t	to the cause of death?	
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that or Attending P its after death. The Director: After the din by the funer. Certification:	3 Suicide 4 Homicide	ome, ferm, str y)	eet, facto	ry, office			(Street end Numb own, State)	ber of Rui	ral Route Number,				
To the Hospital of within 24 hours at To the Funeral Di completely filled it Completely	29a. Certifier (Check only one) 112 Certifying Physician: To the best of my knowledge, death occurred at the time (Check only one) 12 Medical Examiner: On the basis of examination and/or investigation, in my open and menner steted.												
Withir To th comp	29b. Signature en	d title of certifier	11.00	29c. Licanse number					29d. Data signe	d (Month,	, Day, Year)		
	1	n	n 0/9329 3/15/w										
10	30 Name and address of nerson who completed rause of death (florr 93a) (Type Print)												
,	130. Neme end address of person who completed cause of death (Item 23a) (Type, Print) JAGS 1- MESS 7 6565 M. CHALLES ST BALT, MO 213 te 31. Dete filed (Month, Day, Year) 000 324 Register's Signature J. SOCIAL							0 21204					
State	31. Dete filed (Mo	nth. Day. Year 2000	32/ Pegis	trans Signa	iture .	po	ne.						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. 08942 State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Date of Death 3. Time of Death March 14,2000 Month MILLIE E. LANCASTER 6:25pm 4a. Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death SAINT AGNES HEALTH CARE BALTIMORE 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-15-1941 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) 1 □ M 2 10 F Days 225-56-9835 59 Yrs. Virginia Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. tnside City Limits MD BALTIMORE RANDALLSTOWN 1 ☐ Yes 2 X No 10f. Zip Code 10e. Street and Numbar 10g. Citizan of What Country? 3619 KINGS POINT ROAD 21133 USA 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 Û No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Nevar Married Married 1 ☐ Yas 2 ☐ No Specify: BLACK Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machine Operator 12th 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Surnama) Willie D. Sydnor Millie J. Logan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 21133 Lawrence Lancaster 3619 Kings Point Road, Randallstown, MD 20b. Place of Disposition (Nama of cematery, crematory or other place) 3/18/2000 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 ☐ Cramation 3 ☐ Removal from State Arbutus, Maryland Arbutus Memorial Park 4 □ Donation 5 □ Other (Specify) 21. Signature of Funaral Service Licenses 22. Name and Address of Facili HOWELL FUNERAL HOME 4600 LIBERTY HEIGHTS AVE BALTO., MD21207 23a. Part Y. Enter the disease, or complications that caused the death. Do not enter the moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onsat and Death Immediate Cause (Final disease or condition resulting in death) mo Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequance of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospitai: 2 ER/Outpatient 3 DOA

Physician /Medicai Examiner

Physician

/Medical

Examiner

Director

Funeral

by

Completed

Be

2

Funeral

Director

the

Baltimore, Maryland 21215-0020

I is marked other than "natural", or items 23s or 28s-f show traumatic event, the Modical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe any Injury or other traumatic accer-

Examine Physician/Medical by Completed Be 2

Bnd physician 2 # Alber after 6 24 hours • Funeral

68760. Box o Records, Vital Certification: Division

> State Registrar

Medical

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death Other: 4 Nursing Home 5 Residence 8 Other (Specify) Inpatient 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28f. Location (Straat and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. idical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and til

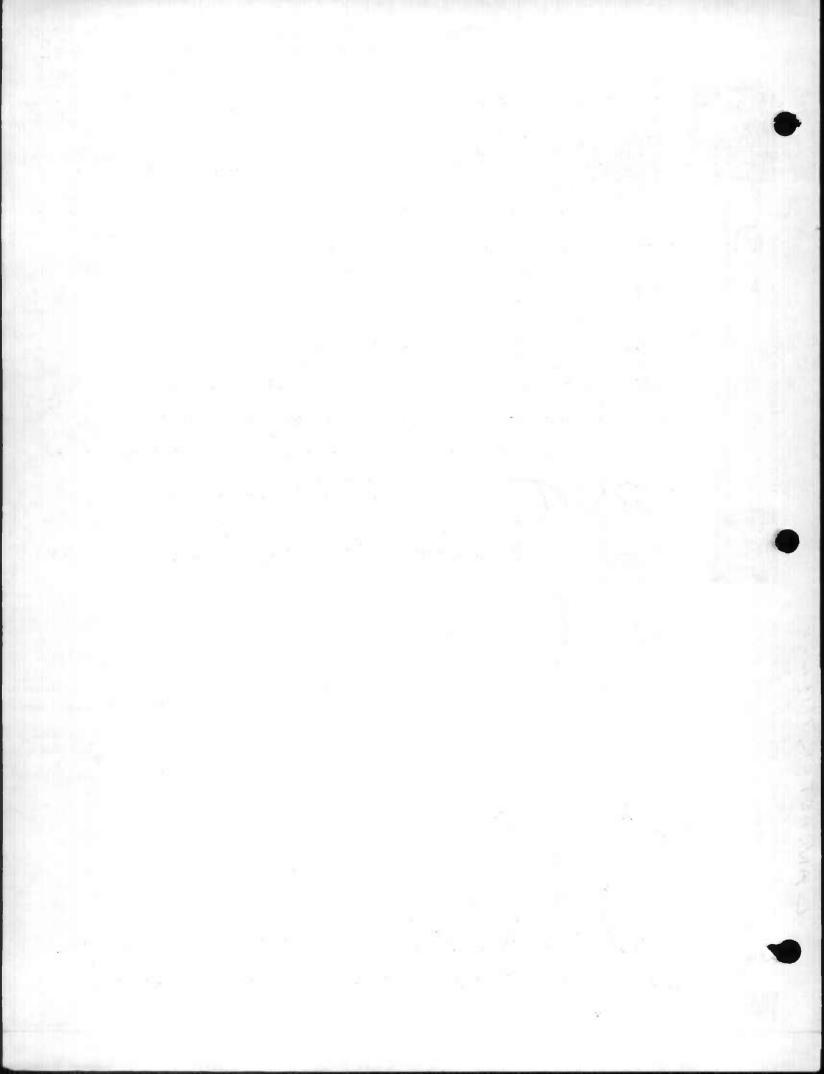
of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) 32. Registrar Signature 2000

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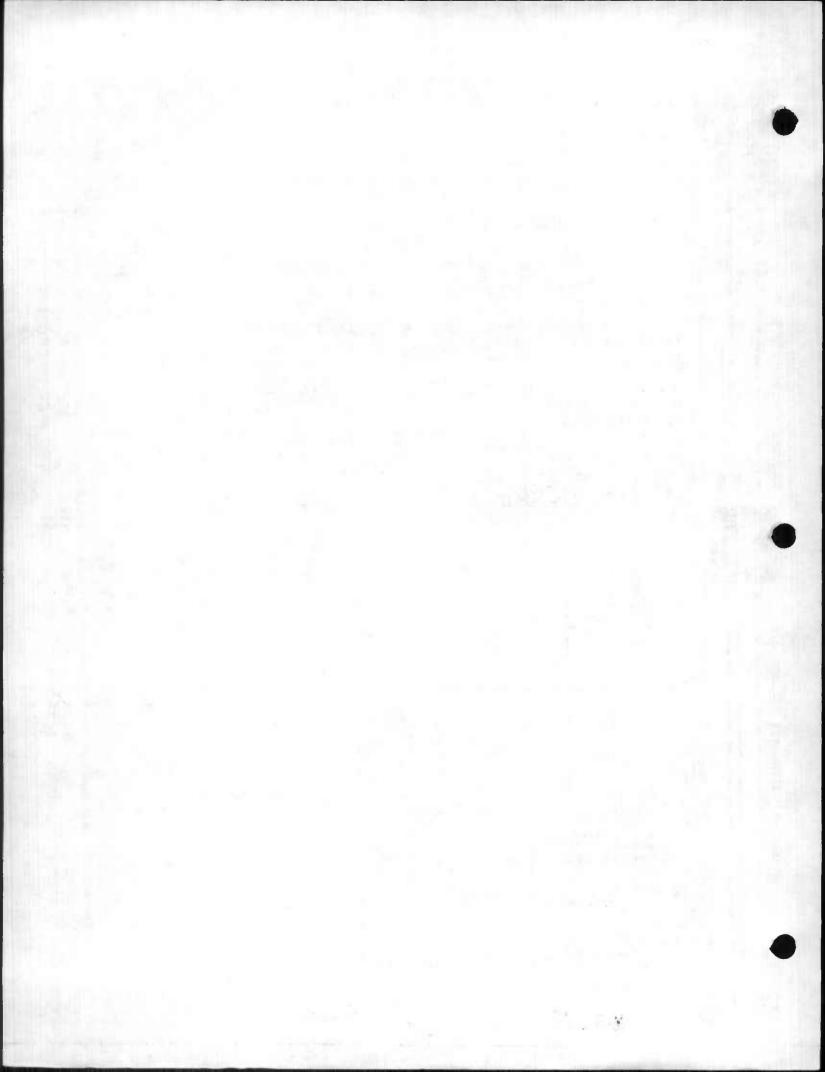
Marvin L. Lucas State of Maryland / Department of Health and Mental Hygiene

Physician		lame (First, Middle, La	st)					2. Date of De	13, Day 200	OYear	3. Time of Death 1050 am
/Medical		ne (If not institution, giv		ber)			4b. City, Town, or L			y of Death	1000 am
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and **	Usual Residence	10b. County		10c. City	y, Town or Loc	cation				11	0d. Inside City Limits
Mary He day	MD	NA		Ba	ltimo	re					1 Yes 2 No
after death with the Marylar or Items 23a or 28a-f show miner must be notified at a Funeral Director	10e. Street and 74 So	Number	le			10f. Zip Code 21234	1		10g. Citizen of US		try?
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72 ho	/S	15. Decedent's Edipecify only highest gra	lucation de completed)		16a. Deced	ent's Usuaf Occu	petion during most of work	cina	16b. Kind of Business/Indust		
within see.	Elementary/Secondary (0-12) 12th Grade		College (1-4	lor 5+)		O NOT use retin	during most of worked)		Beltw	эм п	otel
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al Director: After ted in by the funeric Certification:	3 ☐ Suicide 4 ☐ Homick	6 Could not be	286. Piece of	f fnjury - At ho , etc. (Specify	ome, farm, stre	et, fectory, office			(Street and Num wn, State)	ber or Rura	I Route Number,
Funer Funer Stely fill	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	Certifying Physicfan: To the best of my knowledge, death occu Medical Examiner: On the basis of examinetion and/or investig and manner stated.				ath occurred at the time, date and placa, and investigation, in my opinion, death occurred			anner as st , and due to	lated. the cause(s)
To the comple	29b. Signature a	and title of cartifier	11				se number		29d. Date signs		
	171	who el	land -	7		0.C.	O.C.M.E. March 14, 2000			000	
	THEOD	ddress of person who do			Penn		Baltimore	, Mary	land 212	201	

State Registrar

DHMH 16 Rev 6/95

32. Registrar'a Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08946 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year MARGERY IDABELLE LOWEKAMP 2000 March 13, 1:45 p.m. 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1815 Hamlet Place North Bel Air Harford H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 3, 1905 If Under 1 Year 9. Birthplace (State or Foreign Country) Maryland 5. Social Sacurity Number 7. Age (In yrs. last birthday) Days 1□M 2♥F Yrs. 214-38-4231 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Bel Air Maryland Harford 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 1815 Hamlet Place North 21015 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Yaar or Detes: 1 Nevar Marriad 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) years Teacher Education 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John R. Tucker Ann Cross 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberta Dill (Daughter) 1815 Hamlet Place North. Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 13/17/00 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD 21014 Mais 7 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Immediete Cause (Final STENOSIS diseese or condition resulting in death) HEART DISEASE ScHEMIC Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yes 2 No 1 Yes No 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 A Residence 6 □Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. tnjury at Work? 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No

that the death certificate be executed physician and the burial-tran 58 certificata I or Attending Physician: after death. Director: After this certific 3

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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permit. Pages 1 and 2 should be filed within 72 hours after I Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iter any Injury or other traumatic event, the Medical Estimation

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

death

Director

Funeral

p

Completed

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Physician/Medical Examiner

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Completed

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Certification: To

Medical

3 Sulcide

29e. Cartifier

4 Homicide

(Check only one)

29b. Signature and titla of certifier

Box 68760 P.O. Records, Division of Vital 124 hours a Hospital

completaly

To the To the To the F

State Registrar

31. Date filed (Month

32. Registrar's Signature

assas

6 Could not be determined

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) tree

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

29c. License number

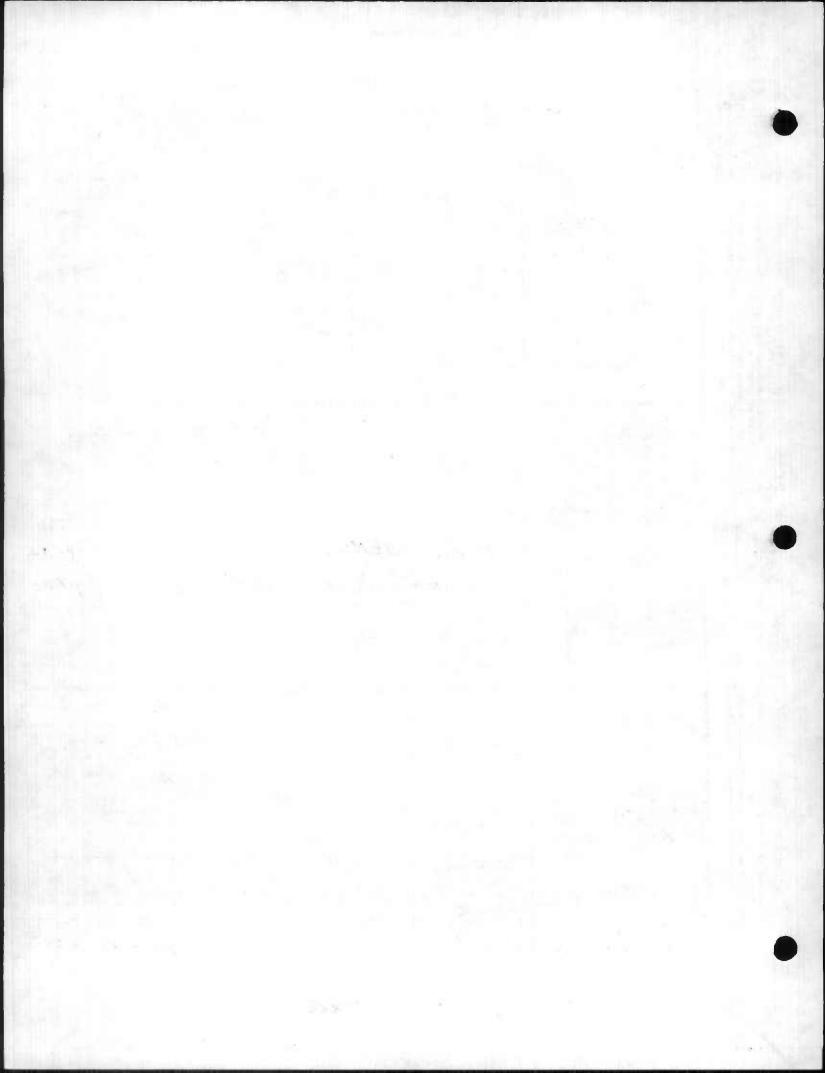
1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year) 2040

28f. Location (Street and Number or Rural Route Number, City or Town, State)

MARCH

d Se 110 BelAir, MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death MARCH 7, Dey 2000 Year **Physician** AGNES THERESA MELITA 8:00PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DUNDALK BALTIMORE EASTPOINT NURSING CENTER Hours Min. 8. Dete of Birth (Month, Day, Year) APR 23, 1913 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Yeer Birthplace (State or Foreign Country) **Funeral** Months 1□M 2□F 86 MD. 218-09-9924 Director Usuel Residence of Decedent 10a. Stete 10b. County 10c City Town or Location 10d. Inaide City Limits must be notified at MD. BALTIMORE EASTWOOD 1 Yes & No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 21224 USA 532 SOUTHERN AVE. Nerns 23a 12. Wes Decedent Ever in U,S. Armed Forces? - should be filed within 72 hours after de-Health and Mental Hygiena. m 27 ie marked other than "nature". Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indian, Bleck, White, etc. 1 Yes 2 No
If Yes, Give X
Year or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry BALTIMORE CITY Elementery/Secondary (0-12) College (1-4or 5+) SCHOOLS HOUSEKEEPING 10 TH 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental WILLIAM PETERSON TINA ANTONINA KARASINSKA 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Addresa (Street and Number or Rural Route Number, City or Town, State, Zip Code) or other tr FRANK R. MELITA/SON 1206 DELBERT AVE., BALTIMORE, MD. 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 XBurial 2 Cremetion 3 Removel from Stete OAK LAWN CEMETERY Department 3/13/00 BALTIMORE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Edneral Service Licenses 22. Neme and Address of Fecility CHARLES S. ZEILER & SON, (set or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, but only one cause on each line. MD.21224 Approximete intervel Between Onset and Deeth **Physician** arteris scleritic Heart Disease /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Physician/Medical Examiner Levis Scleros Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or es e consequence of) Box 68760 Due to (or as a consequence of): igned by the attendin be detached for use Part It. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 2 thknown Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was en autopsy performed? 19 Yes 2 No 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this 27. Manner of Death 1 Diveturel 28a. Dete of Injury (Month, Day Year) funeral 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Yes 2 No r death. 2 ☐ Accident s after death 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 I Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only within 2 \$ 290. Signature and tips of confilling 29d. Date signed (Month, Day, Year) (a-5)

DHMH 16 Rev 6/95

Registrar

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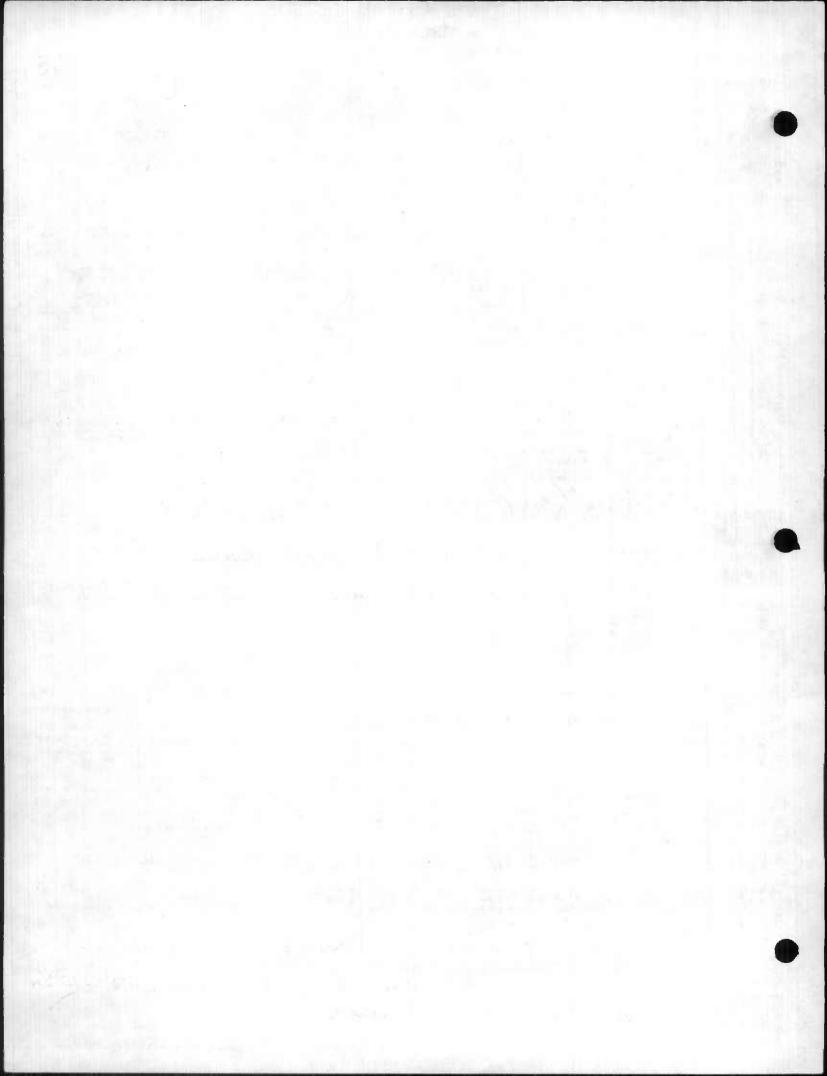
State

MELITO M. TORNES, MD 31. Dete filed (Month, Day, Year) MAR 1 7 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

441 32. Registrar's Signeture

S. ELLWOOD AVENBALTGMD 21224



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Month Day Year Albert 03 2000 Myers 1:00 AM 11 4e Facility Nama (If not Institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW MEDICAL CTR. BALTIMORE N/A If Under 1 Yaar If Under 24 Hrs. Months Days Hours Min. 8. Deta of Birth (Month, Day, Year) AUG. 3, 1933 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foraign Country) Months 1₩ 2□F 216-28-8071 66 MD. Usual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits PA. BEDFORD EVERETT 1 ☐ Yas 2 No 10e. Sfreet and Number 10f. Zip Code 10g. Citizen of What Country? 15537 141 SPRING LANE USA 12. Was Decedanf Ever in U.S. Armed Forcas? 12 Yes ≥ 2 No 17 Yes, Giva Yaar or Datas: 1953-55 Wes Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Indian. 11. Meritel Sfafus Black, White, etc. 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: WHITE 3√Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 11 CABLE INSPECTOR AT & T 17. Father's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) MILTON A. MYERS GERTRUDE C. BROCKSCHMIDT 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE TALLEY/DAUGHTER 29 B MOPEC CIRCLE, BALTIMORE, MD. 21236 20a. Mathod of Disposition 20b. Plece of Disposition (Nama of cematery, cramatory or other place) 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removel from Stete OAK LAWN CEMETERY 3/15/00 BALTIMORE, MD. 4 □Donation 5 □ Othar (Specify) 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility CHARLES S. ZEILER & SON, INC. MD.21224 6224 EASTERN AVE., BALTIMORE, 23a. Part1. Entar the diseasa, or complications that ceusad tha death. Do not antar tha mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximete Interval Between Onset and Death Immediate Cause (Finel disaasa or condition rasulting In daath) Sep515 Due to (or as a consequence of): 12 hours Esophag - jejunostomy Due to (or es a consequence of): anastamotic 36 hours Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disaasa or Injury that initiated avants rasulting in death) Last Resection Gastric Cancer 8 days Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the undartying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown 24b. Wera autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy parformed? 1 Yas 2 No 1 Yas 2 No 25. Was case rafarred to medical axaminar? 26. Place of Deeth (Check only one) Hospital: 1 Impatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidence 8 Other (Specify) 1 Yes 29 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

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Baltimore, Maryland

Box 68760

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Division of Vital

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Examiner Physician/Medical by Completed Be Certification: To

27. Menner of Death

Natural

2 Accidant

3 Suicide

29a. Certifier

4 Homicida

(Check only one)

29b. Signatura and titla of certifier

5 Panding

invastigation

6 Could not be datamined

certificate be executed physician and is the burial-trans 980 signed t The law or Attending Physician: this 124 hours after death. • Funeral Director: A pletely filled in by the fi death. Hospital

To the Hosp within 24 hos To the Fune completely fi

State Registrar

edical

RES 000 WD 30. Name and address of parson who complated ceusa of death (Item 23a) (Type, Print)

28a. Deta of Injury (Month, Day Year)

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

03/11/2000

Department of Surgery Johns Hopkin Hospital DINapol: Michael WD 32. Registrar's Signatura 31. Data filed (Month, Day, Year) MAR 1 7 2000

28c. fnjury at Work?

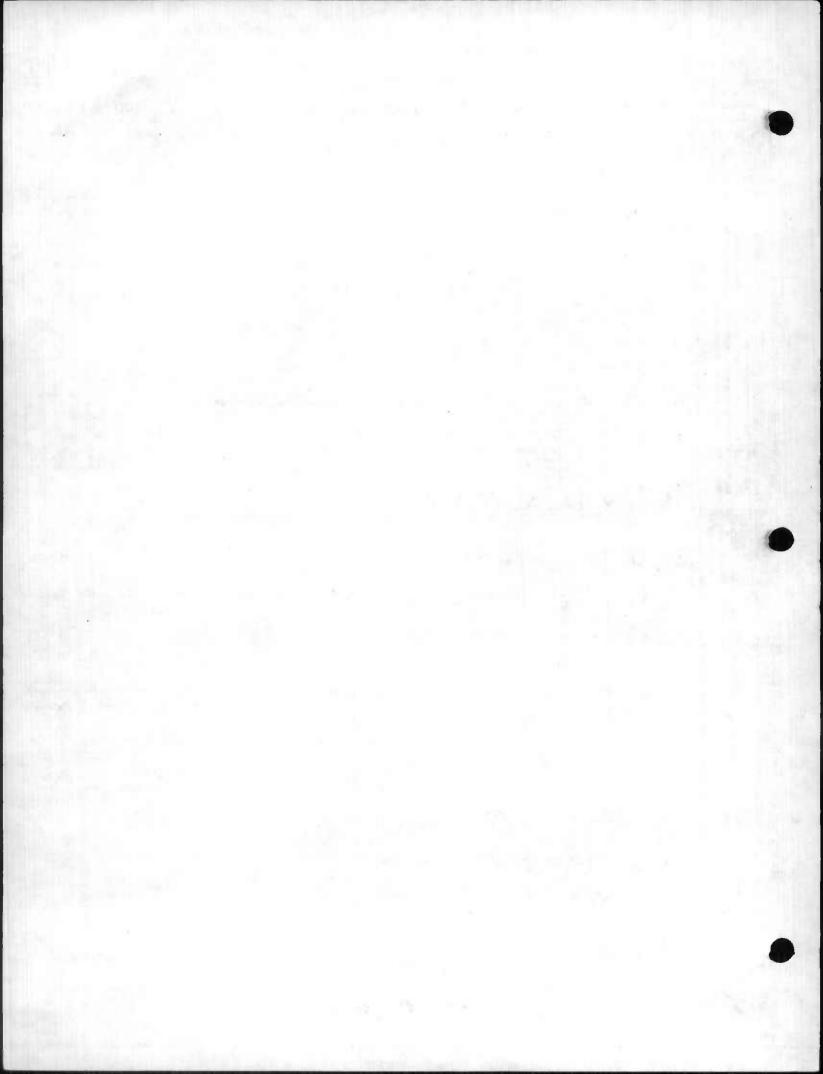
Cordifying Physician: To tha best of my knowledga, daath occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated.

t ☐ Yas 2 ☐ No

DHMH 16 Ray 6/95

28b. Tima of

28a. Plece of Injury - At homa, farm, street, fectory, office building, atc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death AMENDED ITEM #7 PER FH G781 3/17/2000 AH 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth BettyE MANSKY March 8:00AM 2000 12 4e. Facility Name (If not institution, give street and number)
RIUPTILIPIAL COLFE C 4b. City. Town, or Location of Deeth ESSEX

If Under 1 Year If Under 24 Hrs. 8.

Months Days Hours Min. C. Baltimore enter 5. Sociel Security Number 8. Date of Birth (Month, Dey, Yeer) 6. Sex 7. Age (In yrs. lest birthdey) Birthplace (Stete or Foreign Country) 10 M 2 0 F 79 Yrs. March 4, 1922 PA. Usual Residence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. Baltimore Parkville 1 Yes 20 No 10e. Street end Number 10f. Zip Code 10a. Citizen of What Country? 3425 Taylor Ave. 21234 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No White Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) School Teacher Education 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Daniel Mowry Irene Beacher 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Daughter Paula Myers P.O. Box 1853 Belair, Md. 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremetion 3 Removal from State Baltimore Washington Crem. 03/13 4 ☐ Donation 5 ☐ Other (Specify) 21. Signetuural Funeral Service License 22. Neme and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD. 21228
Shock, or heer failure. List only one ceuse on each line. Approximate Intervel Between Onset end Deeth Bronchofeir Concer Melastahc Immediate Cause (Finel disease or condition resulting in death) un-Kum Due to (or as e consequence of) Due to (or as e consequenca of) Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown COPD 24e. Was en eutopsy performed?

Physician /Medical Examiner

buriel-transit

physician s the buriel

attending

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certificate

To the Hospital or within 24 hours effer death.
To the Funeral Director: After this or monoistely filled in by the funeral dir

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Completed

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Certification:

Medical

Box 68760.

P.O. |

Records,

Division of Vital

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Physician

/Medical

Examiner

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Funeral

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with the Maryland

permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene.
Important: If term 27 is marked other than "natural", or Items 23a or 28a-1 show eny injury or other traumatic event, the Medical Examine man be nothing as

Baltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Physician/Medical

210 No

24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No

25. Was case referred to medicat examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Menner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 5 Pending Investigation 1 Naturel 2 Accident 6 Could not be determined 3 Suicide

28c. Injury at Work? 28d. Describe how Injury occurred 1 ☐ Yes 2 ☐ No

Pleca of tnjury - At home, farm, street, factory, offica bullding, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

4 Homtcide

29a. Certifier

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) and menner es stated.
2 Medical Examíner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and pleca, and due to the cause(s) and manner stated.

29b. Signeture end titig of certifier

31. Date filed (Month Day, Yeer) MAR 1 7

29c. License number D-38754

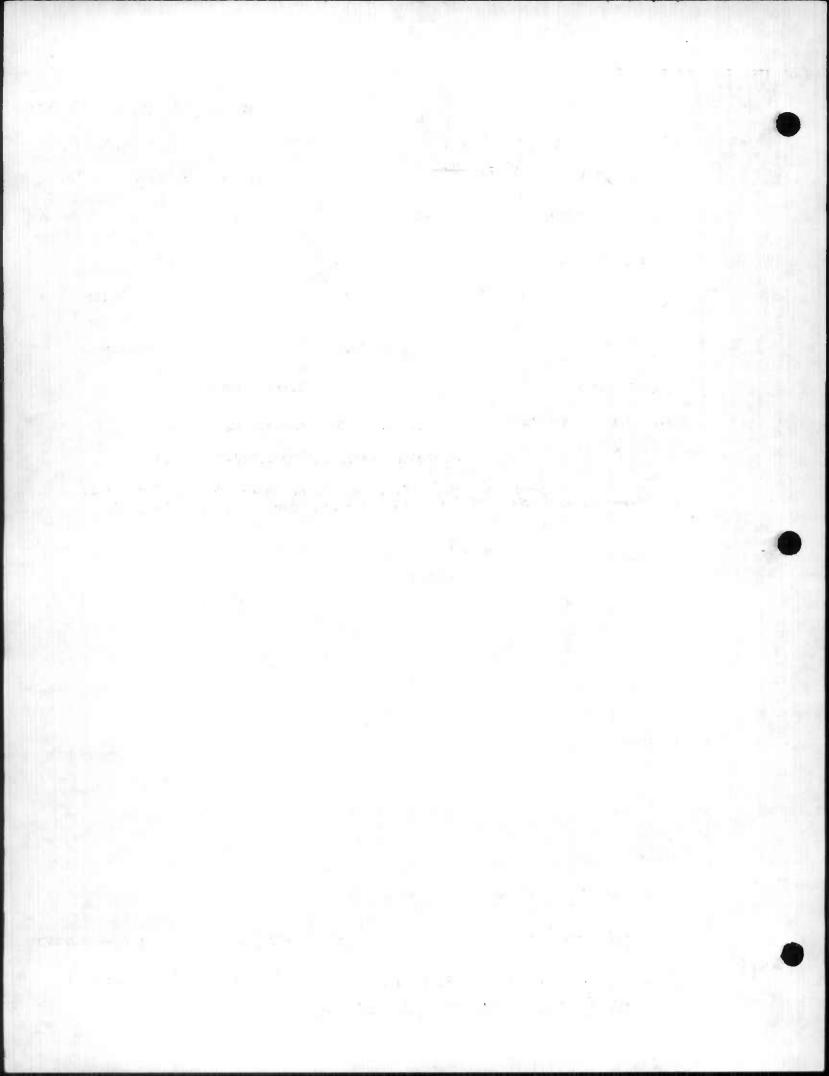
29d. Date signed (Month, Dey, Year) 03-12-2000

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print) INASBEM.,

MD

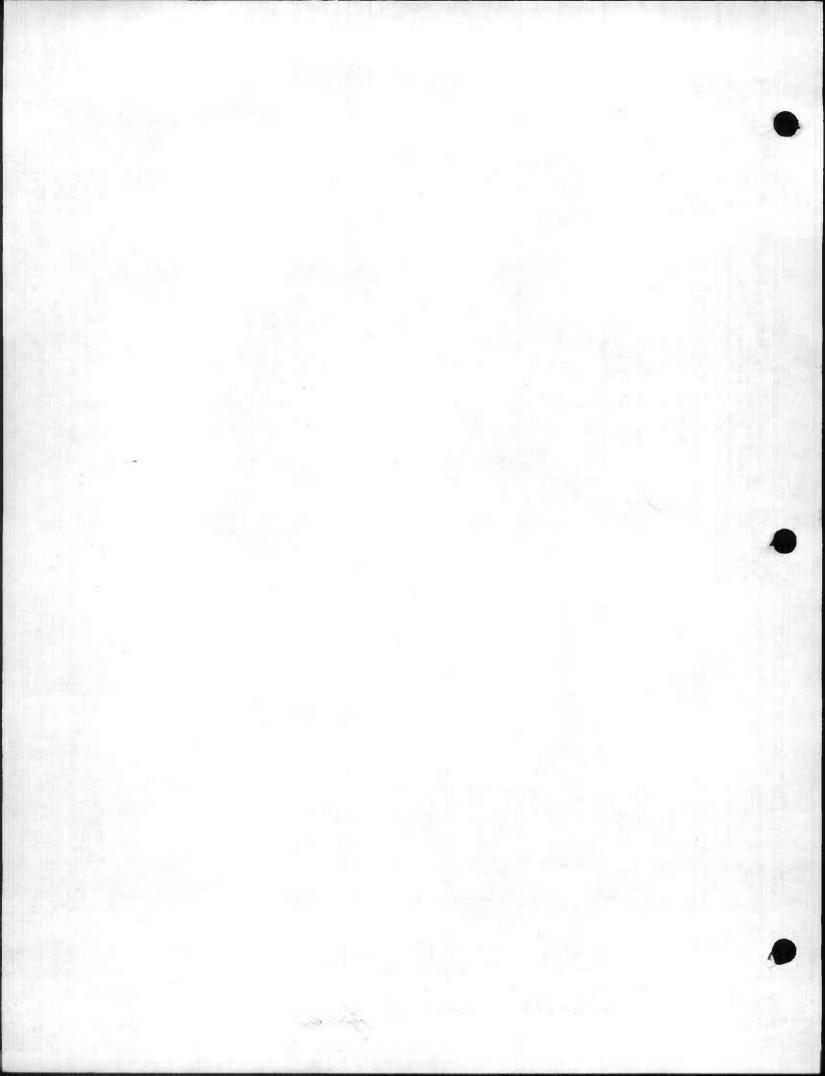
709. BASTERN BLVD, M.D-21221. 32. Registrar's Signature

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

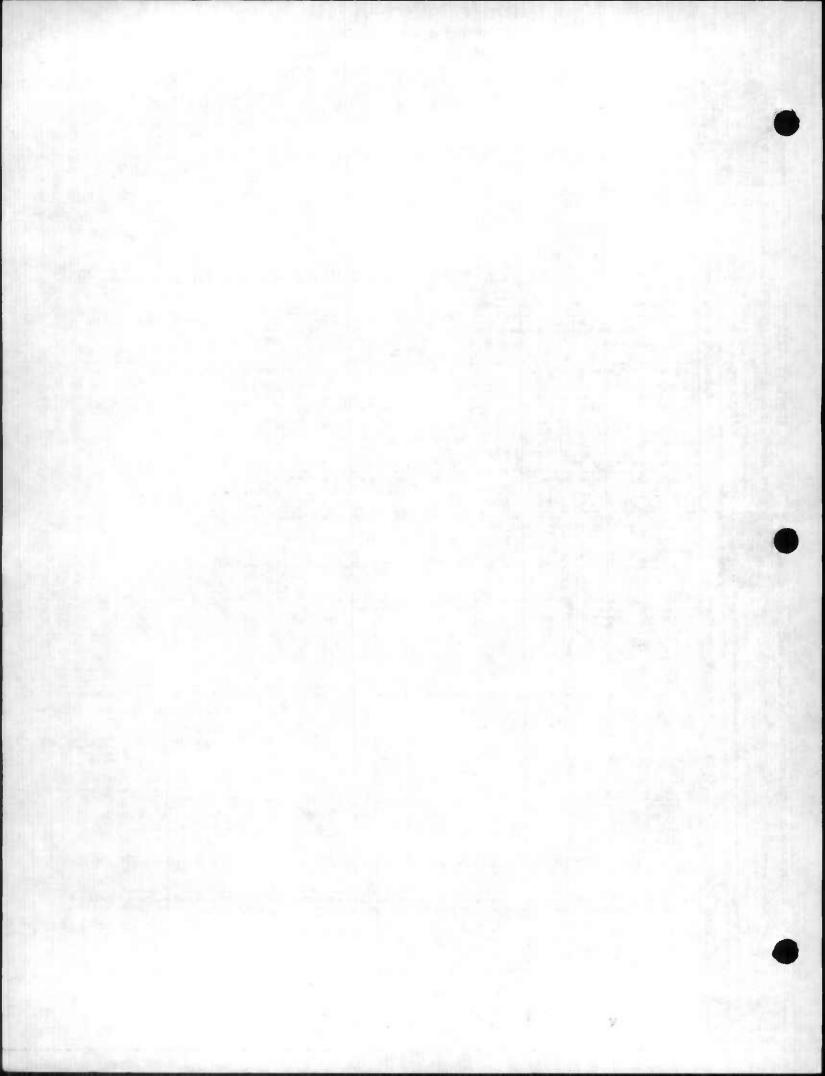
			Certifica	te of Death	Reg. No.	00 08948
Physician	1. Decedent's Nama (First, Middle, Las	· .	0 1 11		2. Deta of Death Month Dey	3. Time of Death
/Medical	JOHN CHA		Naill		MARCH 7	2000 6:45 AM
Examiner	4a Facility Name (If not institution, give	/ - 1		4b. City, Town, or		County of Death
1/4	HOLY (KOSS /4 5. Social Security Number 6. Se	05pital	fact historiani If I Ind	er 1 Year If Under 24 Hr	SPRING /	ON 1801/LERY
Funeral Director	578-03-4821	M 2 F 7. Age (In yrs.	Yrs. Months			9. Birthplace (State or Foreign Country) LAURIN BURG NO
pue *	Usuel Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location		,	10d. Inside City Limits
the Maryler 28s-f show notified at	MD MONTGO	MERY SI	IVER Spi	ZING		1 Nes 2 No
firer deeth with the Mainteer deeth with the Mainteer Sa or 28s-1 since man be notified from an Intercept	2501 MUSGROVE	RO		2090	4	een of What Country? L. S. A.
by Fr.		12. Was Decedent Ever in U Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates://3//3/	1 □ Vec	edent of Hispanic Origin? (ecify Cuban, Mexican, Pue 2 No Specify:		14. Rece - American Indian, Black, Whita, etc. Specify: B/ACK
c 3 = =	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Decedent's Us (Give kind of w life. DO NOT	ork done during most of wo	orking 16b. Kir	nd of Business/Industry
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other of Co	17. Father's Name (First, Middle, Last)			18. Mother's Ne	me (First, Middle, Maiden	Sumame)
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d 2 should be filed with and Mental Hygien The marked other the traumatic event, the	19a. Informant's Neme/Relationship (T)			ss (Street and Number or F	SPEING MO	
Haa Haa othe	20a. Method of Disposition	20b. F	Place of Disposition (Ne cemetary, crematory or	ame of		cation - City or Town, Stete
emit. Pages 1 apparate of Ha mportant: If ham ny injury or oth	1 Deurial 2 Cremetion 3 4 Donetion 5 Other (Specify,	temoval from Stata	eT LINEOLN	CEMETERY		MILLOOD, MD
pemit Depart Import any In	21. Signeture of Funeral Service Licens	in D	383/	and Address of Facility L	YE. HW-WAS	BERL HOME hINGTONDE EDOIL
	23a. Pert1. Enter the disease, or comp shock, or heart feilure. List only of	ications that caused the deat ne cause on each line.	h. Do not enter the mo	de of dying, such es cardie	ac or respiratory arrest,	Approximete fntervel Batween
Physician /Medical	Immediate Causa (Final disaasa or condition	PREUM	04/11			Onset and Death
Examiner	resulting in deeth)	Due to (c	or es a consequence of).		11/3
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e price	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	DEMEN	ILA			YEARS
ufficate as the	resulting in death) Last	Due to (o	r as e consequence of	:		
death cer e attendin ed for use						
the de ny the sched	Part It. Other significant conditions co	ntributing to death but not res	ulting in the underlying	cause given in Pert I.	23b. Did tobacco i	use contribute to the cause of death?
es that the death centioned by the attendin be detached for use by Physician/N					1 ☐ Yes 2 [No 3 Probably 4 Unknown
requir seen s should bould					24a. Wes an autop performed?	sy 24b. Were autopsy tindings aveilable prior fo completion of causa of deeth?
sicien: The law is certificate hes birector, page 2 s					1 ☐ Yas 2 €	No 1 Yes 2010
entifical ctor, p	25. Was case referred to medical			26 Place of De	eath (Check only ona)	10.00 20.00
Physician: The introduction that director, page 1: To Be Com	examiner?	fospitel:	ER/Outpatient 3 C	Other	Home 5 ☐ Residence 6	□Other (Specify)
Physoration or TC	27. Manner of Death	28a. Date of Injury (Month, Day Year)		28c. Injury at Work?	28d. Describe how injury	
f or Attending after death. Director: After d in by the fune ertification	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury M	1 Yes 2 No		
To the Hospital or Attanding Phwithin 24 hours after death. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	3 ☐ Suicide 6 ☐ Could not be detarmined	28a. Place of Injury - At he building, etc. (Specif	ome, ferm, street, facto	ry, office	281. Location (Street and City or Town, State)	d Number or Rural Route Number,
ne Hospital or n 24 hours afte he Funeral Diri pletely filled in edical Cent	29a. Certifier (Check only one) 167 Certifying Physical Examination (Check only one)	siclan: To the best of my kno ner: On the besis of examine and manner steted.	wledge, death occurred tion and/or investigation	d at the time, date and place n, in my opinion, death occ	e, and due to the cause(s) urred at the time, date end	and manner as stated. plece, end due to the cause(s)
within 2 To the comple	29b. Signeture end title of certifier		25	9c. License number	29d. Date	e signed (Month, Dey, Year)
F 3 F 8	1	2 M	D			
5	30. Name and eddress of person who co	empleted cause of death (Item	n 23a) (Type, Print)	Sit-200	Chen Par	7/2000 WE MD. 20901
State	31. Deta filed (Month (Par) Year) 7 2	1000 LOCA 100 32. Registrar's Signa	NOW VE	14118 3236	11 IVER SPRI	06/71.20/01
Registrar	ments T. ()	JUU Deneu	19.	loo. 1		



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State of Maryland / Department of Health and Mental Hygiene 00 08949

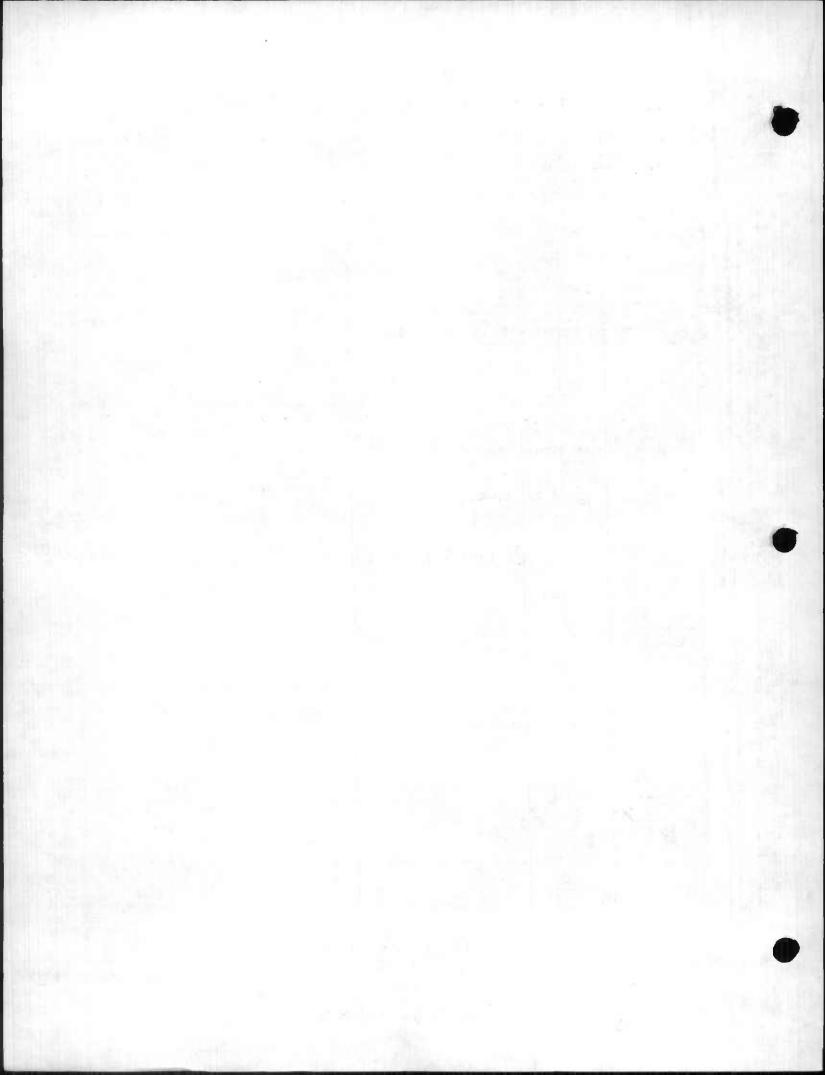
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	cedent's Nama (First, Middla, La	st)							2. Data of Do Month		ay	Year	3. Tima of	
sician edical	Malcolm Eugene Nef	f							March	17	2000	. var	7:15 a	m
	acility Name (If not Institution, giv	e street and numbe	r)				4b. City, To	wn, or Lo	ocation of Dea	th 4	c. County o	f Death		
M	ariner Health						Bel Ai				larford			
	cial Security Number 6. S	ex 7./		last birthdey)	If Undar Months		If Undar Hours	24 Hrs. Min.	8. Data of Bi (Month, D May 11,	rth ey, Yee	0	Coun	lace (Stete o	
	9 - 00-0/41	M.M. SOL	44	Yrs.					May 11,	1955		Penns	ýlvania	l .
	Residence of Decedent State 10b. County		10c. City	y, Town or Lo	cation							1	0d. Inside Cl	ty Limits
b M				est Hill									1 Yes	
Q .	D Harford Street and Number		FOL	est IIII	10f. Zip	Code				10a. C	itizen of WI	hat Coun	try?	
	2001 Columbine Lane					050					ted Sta			
	farital Status	12. Was Deceder	nt Ever in U,	S. 13. V			lispanic On	gin? (Sp	ecify Yas or N Rican, etc.)				an Indian,	
11	Never Married 2 Married	Armed Force:						n, Puerto	Rican, etc.)			, Whita,		
	☐Widowed 4 ☐ Divorced	If Yes, Give Year or Dates			1 🗆 Yes	2∭ No	Specify:				Specify:	White	7	
	15. Decedent's Ed	lucation		16a. Deced	dent's Usua	al Occup	ation during mos	t of work	ina	16b.	Kind of Bus	iness/Inc	Justry	-
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Ele	11			Contra	actor						nstruct			
17. F	ather's Name (First, Middle, Last)								e (First, Middle		n Sumeme)		
P	Malcolm Neff						Shir	ley I	11en Ya	ng				
	Informant's Name/Relationship (_				e/ Routa Numi	-		Stete, Zip	Code)	
	nirley Snyder / mot	ner	205 0	2001			Lane	POLE	st Hill,	7		libr on To	Ctate	
	Method of Disposition I □ Burial 2 ♥ Cremation 3 □	Ramoval from Stat	0	laca of Dispo emetary, cren	netory or o	ther pla	_	1	Date		Location - C		WII, Stata	
-	Donation 5 Other (Specific		Ches	sapeake					3-20-00	BeT	tsville	e, MD		
21. 5	Signature of Funeral Service Licer								ND 04005					
	Laura C	Hardes	ly)								MD 2128	36		
23a.	Part1. Entar tha disease, or com shock, or heart failure. List only	plications that caus one cause on each	ed the death line.	n. Do not ent	er the mod	le of dyin	ng, such as	cardiac	or respiratory	arrest,		- 1	Approximate Interval Bate Onset and I	ween
Imm	adlata Causa /Final											1		
disea	ediata Cause (Final ase or condition Iting in deeth)	a	Pancre	eatic Ca	ncer						_		3 month	S
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6	lting in death) Last		D00 10 (0)	as a conseq	uance orj.									
E C		d										-		
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3									24a. We per	s en eut lormed?		av	ere autopsy i ailable prior t	10
Completed													mpletion of death?	ausa
									10	Yes :	2 XNo	1[☐Yes 2☐	No
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-	lanner of Death XNatural 5 ☐ Pending	28a. Date of in (Month, L	jury Day Year)	28b. Time of Injury	1	8c. Inju Wo			28d. Describe	how inj	jury occurre	d		
2	☐ Accident Investigation				M	1 🗆	Yes 2	No						
4	Suicide 6 Could not be determined	289. Piece of	njury - At ho etc. <i>(Specif</i>)	ome, ferm, str	eet, lector	y, office			28f. Location City or To			r or Rur	il Routa Num	ber,
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-	one) Signature and title of certifier	and manner	stated.		20	Licens	a number			29d D	ata signed	(Month	Day Year)	
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	ame and address of person who				Print)	D 7	A *	N4 7			2101/			
	ott Haswell		orth Av			Bel	Air,	Maryl	and	-	21014			
ate 31. D	ate filed (Month, Day, Year)	32. Regis	tratr's Signa	ture	4	100	1							



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State of Maryland / Department of Health and Mental Hygiene

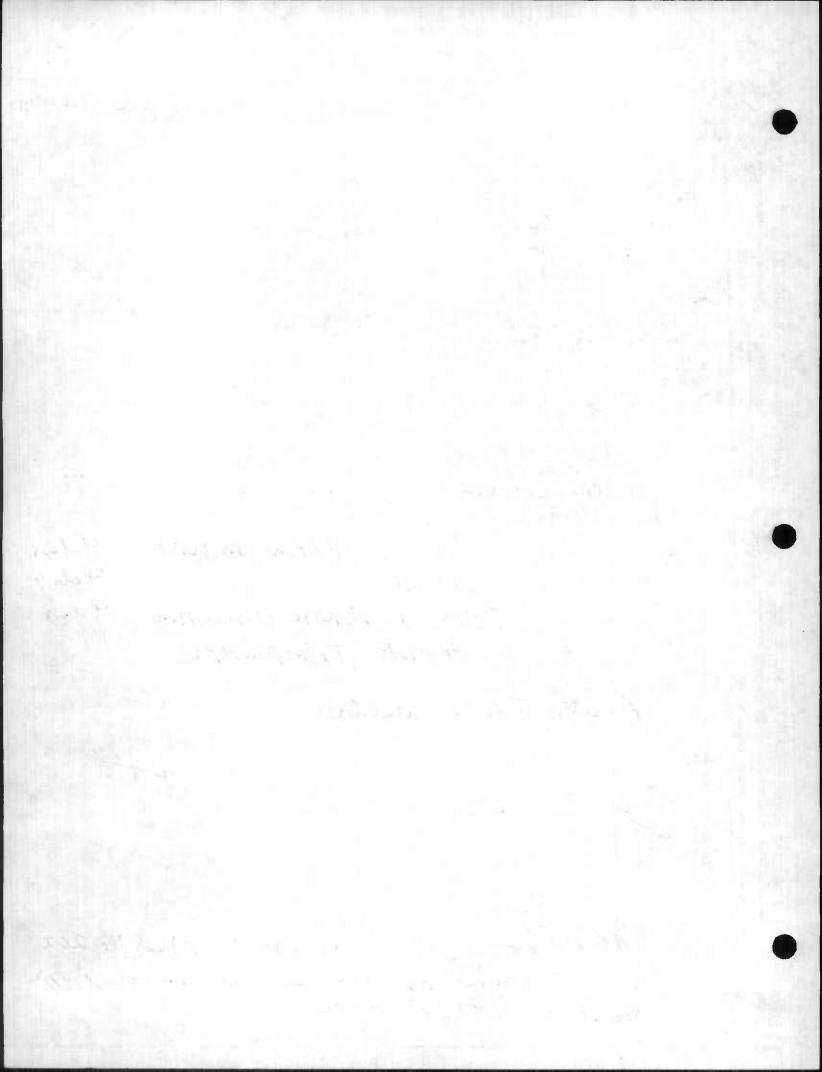
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/Medical	Luzuvein ou		.9		March	15, 20	100 1	:50 PM					
Examiner	4a Facility Nama (If not institution, given 11511 Cedar Lav				or Location of Death	1							
	5. Social Security Number 6. S		last historias) H I m	Kings			imore	'O4-4					
Funeral Director		ex	Yrs. Month		Min. Feb. 29	y. Year) 2	Vermon	Stata or Foreign					
Par II	10a. Stata 10b. County	10c. C	ty, Town or Location				10d. In:	side City Limits					
the Marylar 28a-f show notified at	Maryland Baltimo	re	Ki	ngsville			1[□Yas 2 No					
uth with the Maryla 23a or 28a-f sho ust be not fred at	10e. Street and Number			Zip Code		10g. Citizen of V	What Country?						
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or items	3 Widowed 4 Divorced	12. Was Decedent Evar in U Armed Forces? 1 ☐ Yas 2 ☐ No If Yas, Giva Year or Datas:		cedant of Hispanic Origin? becify Cuban, Mexican, Pu 21X No Specify:	? (Specify Yas or No uarto Rican, atc.)	Specify	e - Amarican Ind ck, Whita, atc.						
ed within 72 ho ygiene. Ser than "naturint, the Hedical	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Decedent's U	sual Occupation work done during most of	working	16b. Kind of Bu	usinass/Industry						
within then then	Elementary/Secondary (0-12)	College (1-4or 5+)	Teacher	use retired)	Elementary Education								
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2 should la market market and Menial La market aumarket To	19a. Informant's Name/Relationship (1	State, Zip Coda	.)										
e, Me 1 and 2 Health as m 27 la wher trau	Mrs. Kaye Newburg Brower (dghtr) 1112 Towood Road, Kingsville, MD 2108												
ore, of Hear	20a. Mathod of Disposition 20b. Place of Disposition (Nama of part of the phoe) Data 20c. Location - City or complete programmer of the phoe)												
Pages nent of int: If its	1 N Burial 2 Cremation 3 Removal from Stata 4 Donation 5 Other (Specify) A Donation 5 Other (Specify) Cermatory, crematory or other place) Moreland Mem'l Park 3/18/00 Baltimore,												
Dalkimore, Maryland 21215-002 permit. Pages 1 and 2 should be filled within 72 hours Department of Health and Mental Hygiene. Important: if them 27 Is marked other than "natural", enty hollury or other traumatic avent, the Wolfred Exp	4 Donation 5 Other (Specify) Moreland Mem'l Park 21. Signature of Funeral Service Licensee 22. Nama and Address of Facility Schimunek Funeral Home, Inc.												
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the dea	th. Do not entar the m	5 BELOUT Ka.	diac or raspiratory at	rast, MU	21236 Appro	oximata					
Physician	shock, or heart failure. List only	ona cause on each lina.						val Between et and Death					
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Examiner	rasulting in death)		or as a consequence of										
D == 00		h					i						
death certificate be assected eath certificate be assected ad for use as the bunel-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (Dua to (or as a consequence of):										
ficate be ay physician is the burie	Cause (Disease or injury that initiated events	C. Dua to (c	or as a consequance o	n:		-							
Med the bear	resulting in death) Last												
us that the death certificated by the attending be deteched for use by Physician/M	116783 4 7 7 2	d											
the desched for	Part II. Other significant conditions co	ontributing to death but not ras	sulting in the underlying	g causa given in Part I.	23b. Did	tobacco use co	ntribute to the c	ause of death?					
	7				10	Yes 2 No	3 Probably	4 Unknown					
necords, r he lew requires that e has been signed b age 2 should be dear					24a Was	an autopsy	24h Wara au	topsy findings					
The lew requir sate has been a page 2 should Completed					perfo	med?	availabla	prior to					
vital neconsider. The lew sentificate has biffrector, page 2 s	100				477	alto/u	of death?						
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Of Vital Ho Physicien: The interpretation of the contificate hural director, page 1: To Be Com.	avaminar?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	Other	Death (Check only o	dence 6 Oth	ar (Snacity)						
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2 249 5	3 Suicide 6 Could not be detarmined	28a. Place of Injury - At h building, atc. (Speci											
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert													
thin 2, the P mplet													
CAN CO	29b. Signatura and title of certifier	101MD-Dhu		29c. Licensa number 29d. Data signed (Month), 3-16-6									
10													
()	30. Nama and eddress of person who o	completed causa of death (Item	n 23a) (Type, Print)	in Sq. Dr	IVE SU	ite 321	BAUT	5. MD					
Contra	31. Data filed (Month, Day, Year)	32. Registrar's Signa	atura 4		10,500	. 10 001	1						
State Registrar	5. Data mos (monat, bay, 10a)		19. A	oake									



State of Maryland / Department of Health and Mental Hygiene 0 0 8 9 5 1

			Cer	tificate of	Death	Re	ng. No.	00201	
	Discostata a	1. Decedent's Name (First, Middle, Last)				2. Dete of Deetl Month	n . Dev Year	3. Time of Death	
40	Physician /Medical	EDNA PROCTOR				Mans	16,200	0 9:23 Am	
).	Examiner	4a Facility Name (If not institution, give street and number)		-	4b. City, Town, or L		4c. County of Des	ith	
		UNION MEMORIAL HOSPITAL			BALTIMO		N/A		
	Funeral . Director	5. Social Security Number 6. Sex 7. Age 1 M 2 F	(In yrs. last birthday) 61 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 6-24-3	Year) 9. Bir	rthplace (State or Foreign ountry)	
29		Usual Rasidenca of Decedent 10a. State 10b. County	I Oc. City, Town or Loc	entine				10d, Inside City Limits	
anyla	a show							1 Ves 2 No	
De X	or 28s-f a be notified Director	MD. N/A	BALTIMOR				On Oldinary of Maria O	Λ	
ath with t	23a or 28a-f ahow unt be notified at ral Director	912 N. ROSEDALE ST		10f. Zip Code 21216			Og. Citizen of What C		
5-0020 72 hours after death with the Maryland	Exercise must lab Funeral l	11. Marital Status 12. Was Decedent Ev Armed Forces? 1 Never Married 2 Married 1 Yes, Give Yeer or Detes:		Vas Decedent of f Yes, specify Cut	Hispanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Raca - Am Black, Whi	ite, atc.	
T 6	ygene. Northan "naturel", It, the Wedes Ex. Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) - 1 2 - 0 - 0 -	(Give I	DO NOT use retire	during most of work ed)	ing	16b. Kind of Business	/Industry	
	ther the		CRAN	E OPERAT			STEEL		
Maryland	Be ver	17. Father's Name (First, Middle, Last) JESSIE LEE JOHNSON			18. Mother's Nam	e (First, Middle, M M. BROW			
aryla	7 le marke treumatic TO	19e. Informant's Neme/Relationship (Type, Print)	19b. Mailin	ng Address (Stree	t and Number or Rui	al Route Number,	City or Town, State,	Zip Code)	
, M	478	DEBORAH DAVIS (DAUGHTER)	1309	LIMIT A	VE. BALTI	MORE, MA	RYLAND 21:	239	
0 - 5	1 5 45 E 45	20a. Method of Disposition	20b. Place of Dispos				20c. Location - City or		
Pages		12 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	KING MEMO			-18-2000	BALTIMOR	E, MARYLAND	
Baltimor	mportant: any injury	21. Signature & Poneral Service Licensee					NERAL HOM		
m &&	SE SE	I fanatha U. Huon	e 17	21-27 N.	MONROE S	T. BALTI	MORE, MAR	YLAND 21217	
/M	ysician ledical aminer	23a. Parth. Enter the disease, or complications that caused the sheck, or heart failure. List only one cause on each line immediate Cause (Finei disease or condition resulting in death)	ne death. Do not ente	c Ta	BRANW			Approximate Interval Between Onset and Death Udwys	
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60, be execute	physician and the burial-transit	if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury	PC I		TILP	15580	non	4 days	
. Box 68760, death certificate be executed	2 5	that initiated events resulting in deeth) Last	AMIA		Ampo	NAPE		4 days	
Geath Geath	d for	Part II. Other significant conditions contributing to death but	not resulting in the ur	nderiving cause g	iven in Part t.	23b. Did to	bacco use contribut	te to the cause of death?	
P.O.	igned by the attendiibe detached for use by Physician/I	1 1 -	a- Ws				1 Yea 2 No 3 Probably 4 Unknow		
Records,	should should					24a. Was a perform		. Were autopsy findings available prior to completion of cause of death?	
- R	page 2					1□ Ye	s 2 DNO	1 ☐ Yes 2 ☐ No	
	certificate rector, pag b Be Co	25. Was case referred to predical			26 Place of Dea	th (Check only on			
of Vita		examiner? 1 Yas 2 1 No Hospital: 1 Inpatient	2 ☐ ER/Outpatien	nt 3 DOA	thor:		nca 6 □Other (Sp	ecify)	
	2 2	27. Menner of Death 1 Death 5 Pending 28a. Date of Injury (Month, Day)	28b. Time of	28c. Inju			w injury occurred		
Division or Attending	- A	2 Could not be	y - At home, farm, stre (Specify)			28f. Location (St City or Town	reet and Number or F o, State)	Rural Route Number,	
To the Hospital	To the Funeral Di completely filled in	29a. Certifier (Check only 2 Medical Examiner: On the basis of e	xaminetion end/or inv						
# id	Med	one) and manner state	a.	29c 1 ions	se number	0	9d: Date signed (Mor	oth Day Year)	
P 3	0 0	29b. Signature and title of certifier							
,		11/1		N	4) > 84	7/	1 (acc) /	Q, Luc	
_ (()	30. Name and address of person who completed cause of dea	th (Item 23a) (Type, I	Print)	ium n	rama	mc 64	(e, 2000)	
er e	State Registrar	31. Date filed (Month, Day, Year) MAR 1 7 2000 32. Aegistrar	s Signature 6.	Spark					

DHMH 16 Rev 6/95



Please Type or Print in Biack Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death Day Month Year LENA ERMA PONTIER MARCH 15, 2000 7:00 P.M. 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Genesis Eldercare- Hammonds Lane Brooklyn Park Anne Arundel 8. Date of Birth (Month, Day, Year) Dec. 25, 1904 9. Birthple Counti If Under 1 Year | If Under 24 Hrs. 9. Birthplace (Stata or Foraign Country) West Virginia 5. Social Security Number 7. Aga (In yrs. last birthday) Deys Months Hours 1□M 2☑F Yrs. 95 235-10-5507 Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yas 2 No Maryland Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7401 Mulberry Road 21076 U.S.A. 14. Race - Amarican Indian, 12. Was Decedant Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, atc.) Black, Whita, etc. 1 ☐ Nevar Married 2 ☐ Merried 1 ☐ Yes 2 ☑ No 1 Yas 2 No Specify: Specify: 3 ₩ Widowed 4 Divorced White 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) Manager Airplane Manufacturer 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Daniel Smith Nancy Clifton 19a. tnformant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Mary McEachern- Niece 208 Forest Avenue, Rockville, Maryland 20850 20b. Place of Disposition (Name of cemetery, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Crametion 3 ☐ Ramoval from Stata Lorraine Park 3/20/00 4 ☐ Donation 5 ☐ Othar (Specify) Baltimore, Maryland 21. Signature of Flyndrel Service Licensea 22. Nama and Addrass of FacilitySINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061 Moder 23a. Part 1. Entar the disease, or emplications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death tmmediata Causa (Final disaasa or condition resulting in deeth) poxemia hours Due to (or as a consequance of): Demen KA zheimers Sequentially list conditions, if any, laading to immadiate causa. Enter Underlying Causa (Disease or Injury that Initiated evants resulting In death) Last Dua to (or as a consequence of): Dehydration o (or as a consaquance of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably W Unknown 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2K No 1 ☐ Yes 2 ☐ No 25. Was casa rafarred to medical axaminar? 26. Placa of Death (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Data of tnjury (Month, Day Year) 27. Mennar of Death 28d. Describe how injury occurred 28b. Tima of 28c. tnjury at Work? Natural 5 Pending 1 Yas 2 No invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 28a. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

Be

Funeral

Director

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or flams 23s or 28s-f

altimore, Maryland 21215-0020

Box 68760.

Records, P.O.

Division of Vital

warylanc permit. Pages 1 and 2 should be file Department of Health and Memai Hyp important if item 27 is marked any injury or other 2005s.

Examiner

Physician/Medical à Completed Be Certification: To Ne Hospital or Attending 124 hours after death
He Funeral Diractor: /

4 Homicida

(Check only one)

29b. Signature and Maril certifier

29a. Certifier

sician and burial-transit be executed the 980 signed by the a or Attending Physician: this

DHMH 16 Ray 6/95

To the To the T

death.

State Registrar

edicai

completely

ROAD Suite 100 CAKWOOD Day, Year) 32. Registrar's Signature MAR 1 7 2000

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print)

(Certifying Phyatcian: To the best of my knowledga, daeth occurred at tha tima, data and place, and due to the cause(s) and manner es stated.

29c. Licensa number

ORIGINAL

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

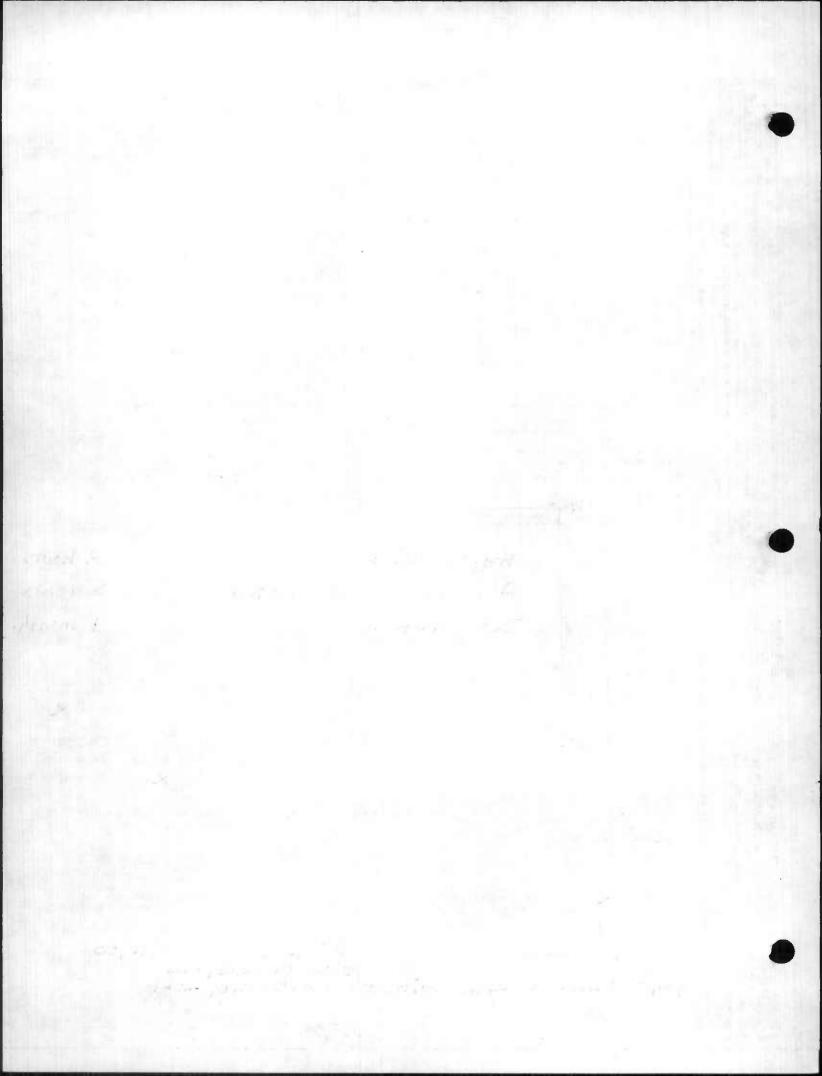
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

00

D53462

Jude Muneses, MA

Glen Burnie,



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month De Year **Physician** ROSE M. PERSKIE 03 12 2000 1:20 a.m. /Medical 4a Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | if Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Hours Months Devs 1□M 2♥F Yrs 88 Director 216-03-4601 04/03/1911 PA. Usuel Residence of Decedent with the Maryland 10a State 10b County 10c. City. Town or Location 10d Inside City Limits r than "naturel", or items 23s or 28s-f show the Wed cal Examiner must be notified at MD BALTIMORE BALTIMORE t ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6912 TEN TIMBERS LANE 21209 USA Funeral death 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ☒ No Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, 11 Meritel Status Bleck, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Merried Maryland 21215-0020 If Yes, Give Yeer or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify: WHITE by 3 X Widowed 4 ☐ Divorced Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) permit. Pages 1 and 2 should be filed within 72. Department of Health and Montal hyglene. Important: If Item 27 ie marked other than any injury or other Elementery/Secondary (0-12) College (1-4or 5+) BOOKKEEPER FURNITURE 18 Mother's Name (First Middle Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be JOSEPH MORGAN MARY OCHEROFF 10 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) PATRICIA L. PERSKIE/DAUGHTER 6912 TEN TIMBERS LANE BALTIMORE, MD Baltimore. 20b. Plece of Disposition (Neme of cemetery, crematory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 N Burial 2 Cremetion 3 Removel from Stete ARLINGTON-CHIZUK AMUNO 3/14/2000 BALTIMORE, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service Licensee 22. Name end Address of Fecility SOL LEVINSON & BROS, INC. 8900 REISTERSTOWN RD, PIKESVILLE, MD 21208 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heert feilure. List only one cause on each line. Approximate Intervet Between Onset and Death Physician /Medical Immediete Ceuse (Final disease or condition resulting in death) WEEKS e RESPIRATORY FAILURE Examiner Due to (or es e consequence of): Examiner b. COPD WEEKS physician and the bunal-transit certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Box 68760 c. INTERSTITIAL LUNG DISEASE YEARS Physician/Medical Due to (or es e consequenca of): 88 for use as signed by the a Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown à 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en eutopsy Completed peed has page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 No Division of Vital director 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funeral 27. Menner of Death 28d. Describe how injury occurred 28b. Time of Certification: 28e. Dete of Injury (Month, Dey Year) 28c. fnjury at Work? 1 XNeturel 5 Pending death. 1 Yes 2 No investigation 2 Accident or Attendation after death 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of fnjury - At home, ferm, street, fectory, office building, etc. (Specify) completely filled in by 4 Homicide Hospital
 24 hours a
 Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of exeminetion end/or investigation, in my opinion, deeth occurred et the time, dete end place, and due to the cause(s) end menner stated.

To the To the To the I

29a. Certifier

(Check only one)

29b. Signaldre and title of Certified

edical

JOHN ROGERS, M.D., MORGAN 502, 5601 LOCH RAVEN BLVD, BALTO, MD 32. Registrer's Signeture

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

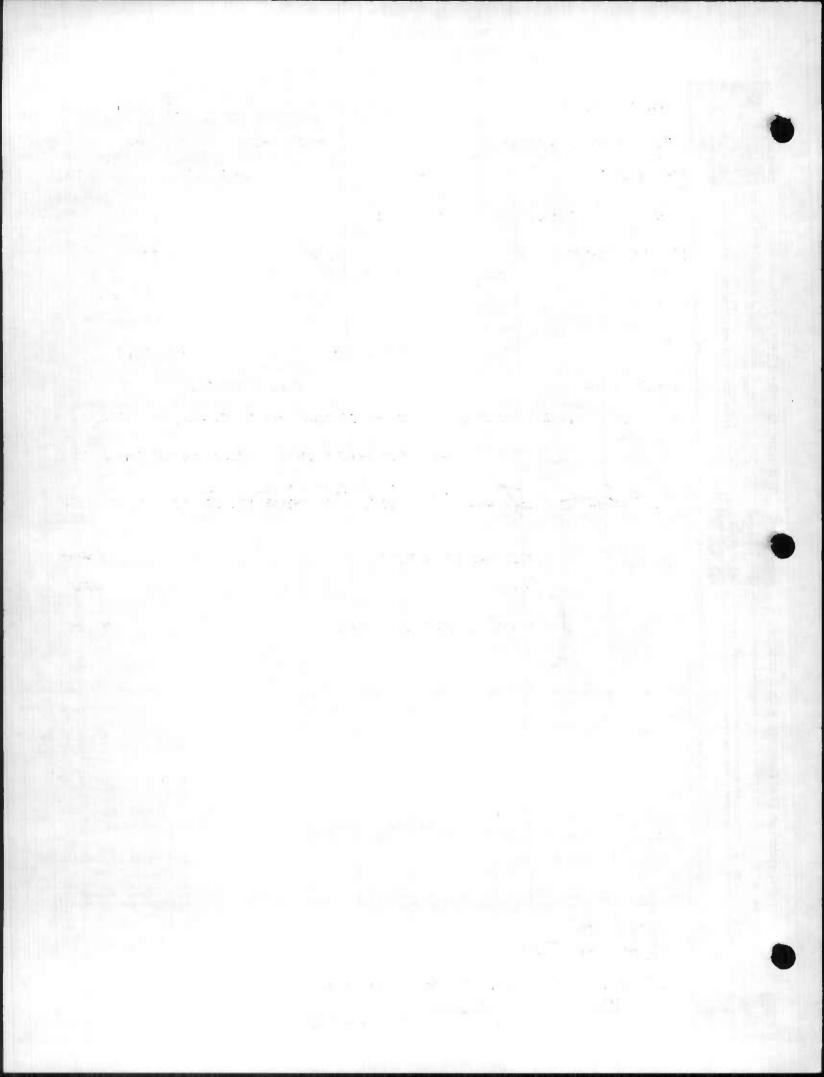
Sparke

29c. License number D16534

29d. Date signed (Month, Dey, Year)

03/15/2000

Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 8:40 A KEIVES 16, 2000 4c. County of Death TOWARD JAMES March /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hospita timore more If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) JULY 25, 1927 7. Age (In yrs. last birthday) 5. Social Security Number 6) Sex If Under 1 Yeer Birthplaca (State or Foreign Country) **Funeral** Days Months 1 M 2 F 72 213-20-777 NORTHC Director Usual Residenca of Decedent the Marylend 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1. Yes 2□No oward Director MARYLAND 10e. Street and Number 10g. Cifizen of What Country? 8 234 KOAL USA Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Dates: 1 ☐ Never Married 2 ☐ Married 8 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 □ Divorced BLACK Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Known > Elementary/Secondery (0-12) College (1-4or 5+) Hygiena. KAILROAN O +H GRADE ABORER Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 end 2 should be finent of Heelth and Mentel ! REIVES MACK EMERSON ENA 19e. Intermant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 0 t or other tr 3454 BALTTHORE, MD, 21229

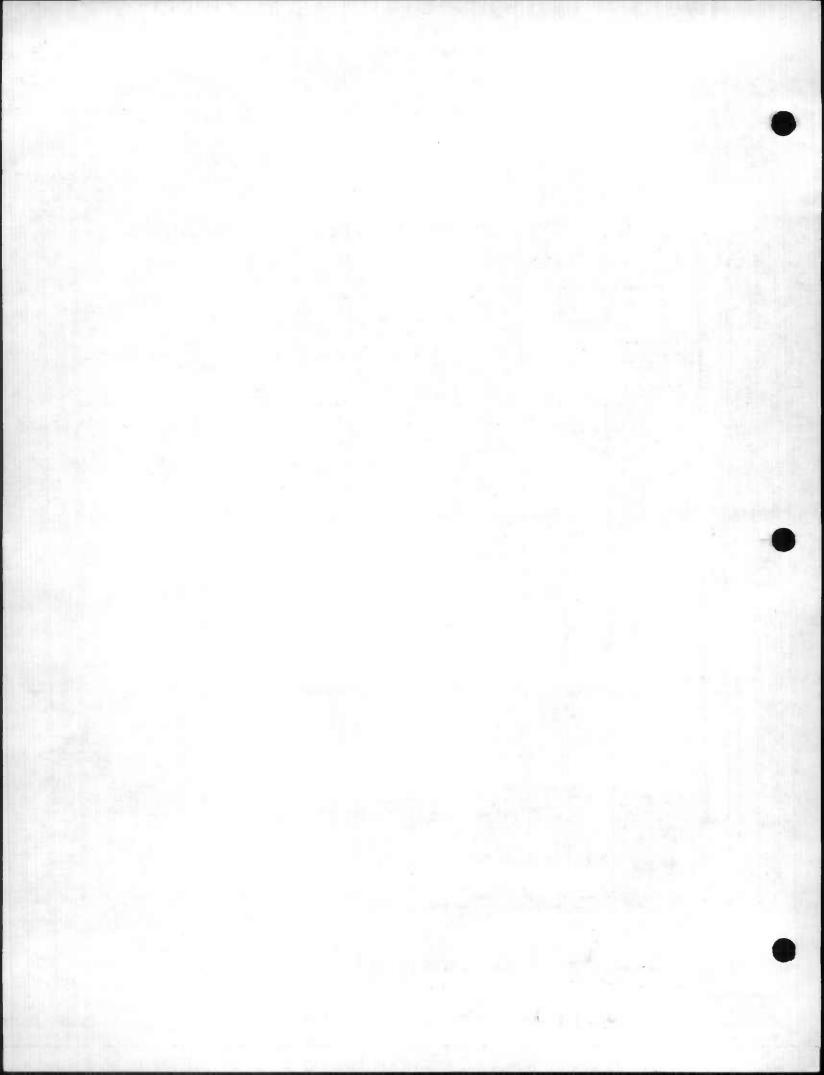
20c. Location - City of Town, State TH CATON AVE. GREE Baltimore, 20b. Placa of Disposition (Name of cametery, cremetory or other place) 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CEMETERY ANS DOWNE, HARYLAND 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility BROW. TR. FUNERAL HOME 2140 N. FULTON AVE BALTIMORE, MD. 2121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirate shock, or heart tailure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final eumonia disease or condition resulting in death) Examiner Due to (or es a consequence ot) Physician/Medical Examiner Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence ot): Box 68760. the Due to (or es e consequenca of) P.O. Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Records, Be Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 1 Yes certificate Division of Vital or Attending Physician: 25. Was case reterred to medical axaminer? 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 ER/Outpatient 3 DOA this 27. Magner ot De 1 Natural 2 Accident 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? After 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Placa ot Injury - At home, tarm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier (Check only one) completely within 2 To the \$ 29b. Signapure and title of 29c. License number 29d. Date signed (Month, Day, Year) 2000 7 30. Name and address of person d cause ot death (Item 23a) (Type, Print) Baltimore HD 21215 Hospi Sinai 240 LW 31. Date tiled (Month, Dey, 32. Registrar's Signature State

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

DHMH 16 Rev 6/95

Registrar



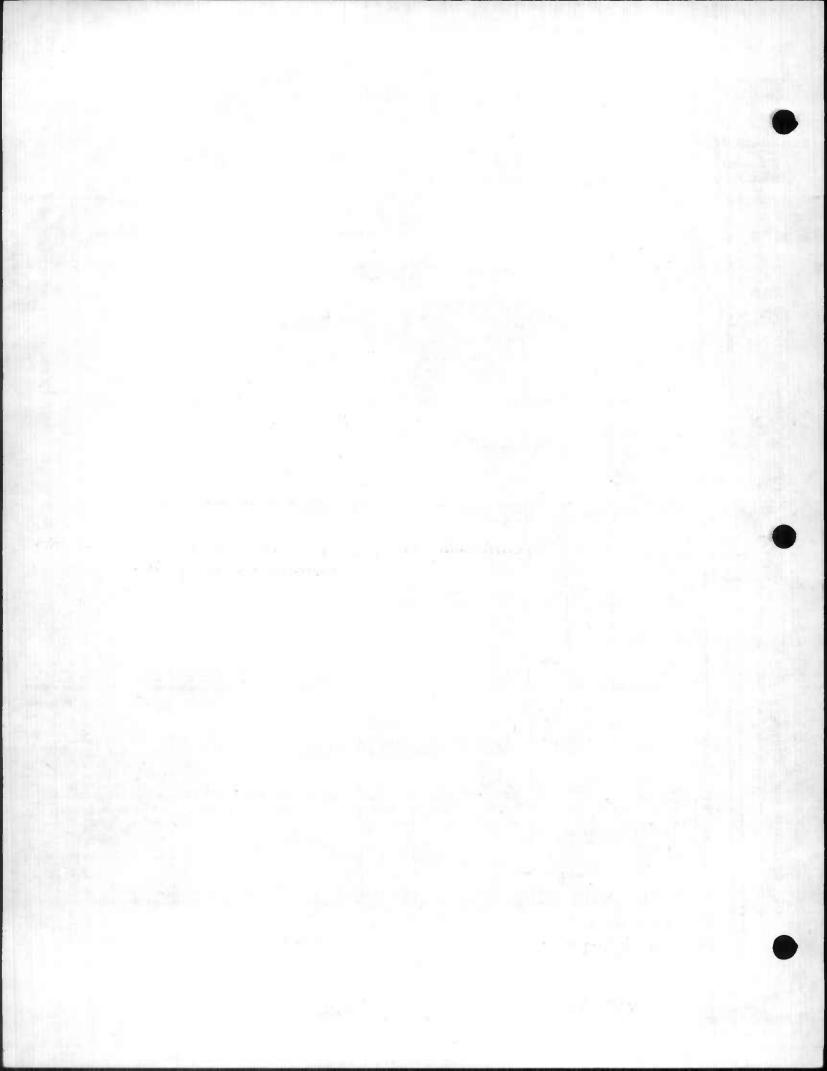
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year 2000 MARCH 13 4c. County of Death 4b. City. Town, or Location of Death Fallston Harford If Under 1 Year 8. Date of Birth (Month, Day, Year) Sept. 18, 1943 7. Age (In yrs. last birthday) 1以M 2□ F 56 Vrs 10c. City, Town or Location 10b. County Harford Edgewood 10g. Citizen of What Country? 10f. Zip Code

Physician 1258 pm THOMAS EUGENE RICKS, SR. /Medical 4a Facility Name (If not institution, give street end number) Examiner Fallston General Hospital 9. Birthplace (State or Foreign Gountry) North Carolina 5. Social Security Number **Funeral** 240-68-4054 Director Usual Residence of Decedent 10a. State 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Hedical Examinar must be notified at 1 ☐ Yes 2 No Director Maryland 10e. Street and Number 1563 Charlestown Drive 21040 U.S.A. deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. e filed within 72 hours effer-al Hygiene. other than "natural", or ite 1 Tyes 2 No
If Yes, Give
Year or Detes: 1962-66 1 Never Married 2 X Merried aitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: by 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 years Supervisor Distillery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peges 1 and 2 should be fill ment of Heelth and Mental Hamt: If Item 27 is marked out 8 Walter McCray Jr. Naomi Ricks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggie Ricks (Wife) 1563 Charlestown Drive. Edgewood. MD 21040 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 Cremetion 3 Removel Irom Stete permit. Pege Department of important: If eny injury or page. 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gardens: 3/18/00 Bel Air. 22. Name and Address of Fecility Schimunek Funeral Home of Bel Air, Inc. 21. Signature of Funeral Service Licensee 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset end Death **Physician** 45 min /Medical Immediate Cause (Finel will Ventricular Tachycordia disease or condition resulting in death) Examiner Due to (or as a consequence of): magnetic Disassociation Examiner physicien end s the burief-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contributa to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown been signed be dete p Records, 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? Completed completion of cause of death? 1 Yas 2 No 1 Yes 21000 Vital at or Attending Physicien: T setter desth. if Director: After this certificat of in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA Division of 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28a. Place of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hoepital or within 24 hours eft To the Funeral Di completely filled in to Cortifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) S. Raguray 03/14/00 WD 53720

LHOWAS 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Sinnarajah Raguraj M.D. 2112 Belair Road. Fallston. MD 32. Registrer's Signeture State Registrar DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Neme (If not institution, give street and number) 4b. City, Town, or Kocation of De 4c. County of Deeth N/A 5. Sociel Security Namber 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1₹M 2□ F 84 213-03-7589 6-29-15 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Rosedale 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7100 E. Biddle Street 21237 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Wes Decedenf Ever in U,S. Armed Forces? Race - American Indian, 11. Meritei Stetus Black, White, etc. Yes 2□No Yes, Give 1 ☐ Never Merried 2 ☑ Merried 1 ☐ Yes 2 ☑ No Specify: white Specify: WW II 3 Widowed 4 Divorced Yeer or Detes: Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondery (0-12) Coilege (1-4or 5+) C&P Telephone 12 4 Copper Worker 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Frances Hupka Charles Ruby 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 7100 E. Biddle St. Rosedale, MD Marie Ruby / wife 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 3-16-00 Baltimore, MD 21. Signature of Pagerel Service Licenses 22. Neme and Address of Facility Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 23a. Pert1. Enter the diseese, or complications that ceused the shock, or heart failure. List only one ceuse on each find eeth. Do not enter the mode of dying, such Approximate Intervel Between Onset and Deeth Immediete Cause (Finel disease or condition resulting in deeth) Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Wes an eutopsy 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes cese reterred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Menner of Death 28d. Describe how injury occurred 28e. 28b. Time of 28c. Injury at Work? Dete of Injury (Month, Dey Year)

Physician /Medical **Examiner**

Physician /Medical

Examiner

Director

Funeral

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Completed

Be

10

Funeral

Director

23s or 25s-f

Barras

8

filed within 72 hours after

Pages 1 and 2 should be nent of Health and Mental

Is marked

Department of Health a Important: If Item 27 is any injury or other tras

altimore, Maryland 21215-0020

P.O. Box 68760. Vital Records, The law certificate oto 불 After

Physician/Medical

by

Be Completed

Division Attending after death. To the Hospital or A within 24 hours after To the Funeral Direc

Medical Certification: To State Registrar

29b. Signeture and title of certifier Zegwall m

5 Pending Investigation

8 Could not be determined

Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) end menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29c. License number

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Dete signed (Month, Dev. Year)

30 Home and address of purson who completed cause of Seeth (Item 23a) (Type, Print)

31. Dete filed (Month, Dey, Year) MAR 1 7 2000

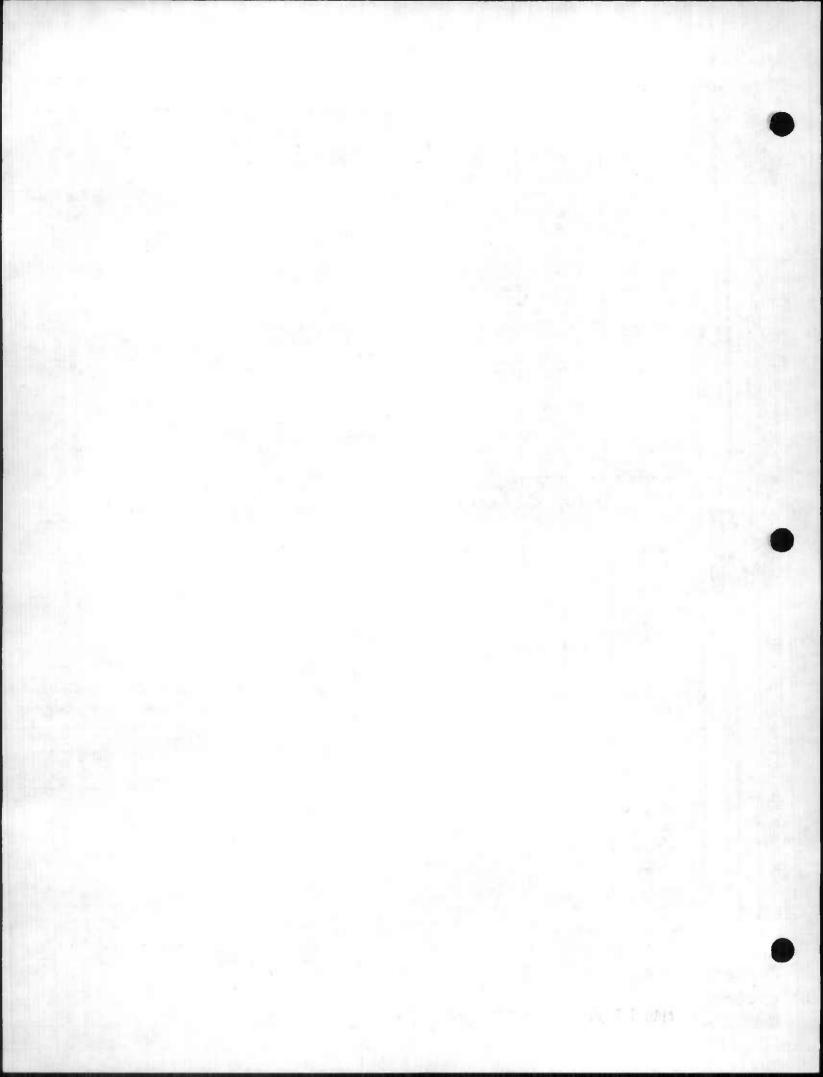
1 Netural 2 Accident

3 Suicide

29a. Certifier

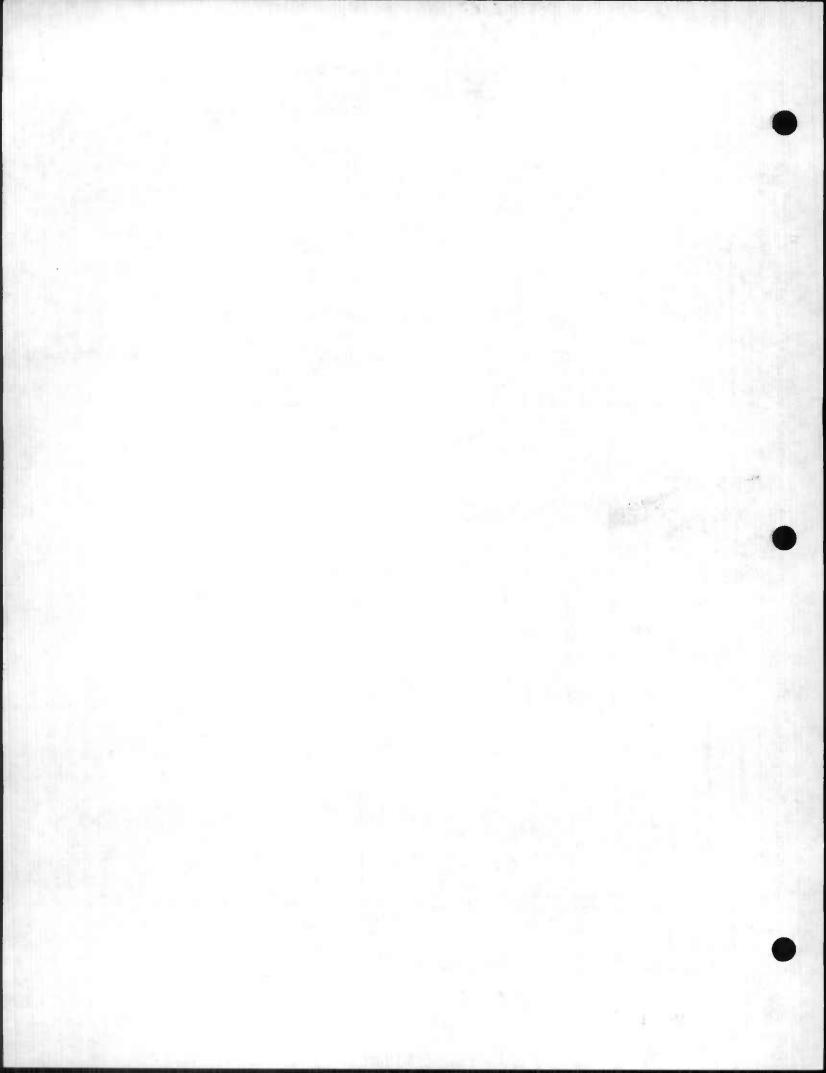
4 Homicide

32. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene 00 08957

				Ce	rtificate d	of Death	7	B	eg. No.	0	0 0 0 .	
		1. Decedent's Name (First, Middle, La	st)	TEE				2. Data of Deal		Yaar	3. Time of Death	
1	Physician (Madical	Anna	M.		Rogow	ski		Month	Day 13,200		11:35 AM	
	/Medical Examiner	4a Facility Nama (If not institution, giv			nogow		own, or Lo	cation of Death	4c. County			
		Genesis Elder Ca	re/Perring	Parkway	Center	Pa	rkvil	lle	Balt	timore	9	
	Funeral Director	5. Social Security Number 6. S 213–28–3120	D	n yrs. lest birthdey Yrs.	If Undar 1 Ya	aar If Under lys Hours	r 24 Hrs. Min,	8. Data of Birth (Month, Dey 3-21-	Year)	9. Birthpla Country	ce (Stete or Foreign NJ	
	9	Usual Residence of Decedant										
	a Marylan last show difed at ctor	MD Baltin		Oc. City, Town or L ROSE	ocation dale		Wh.			100	d. Inside City Limits 1 ☐ Yas 20 No	
	r death with the Maryle terns 23a or 28a-f sho er must be notified at uneral Director	10e. Street and Number 8111 Duvall Av	æ.		10f. Zip Coo	2123	7	1	0g. Citizan of W US		y?	
050	uraf, or Herra at Examiner m of by Fune	11. Marital Status 1 □ Nevar Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yas 2 No If Yas, Giva Yaar or Datas:	ar in U,S. 13.	Was Decedent If Yas, specify (1 ☐ Yas 2 ☐			cify Yes or No- Rican, etc.)		e - Amaricer k, Whita, at Whi	c.	
5-0	公 草体 無	15. Decedent's Ed (Specify only highest gra	lucetion de completed)	16a. Dece (Give	edant's Usual Oc e kind of work do DO NOT use re	cupation one during mo	st of working	ng	16b. Kind of Bu	siness/Indu	stry	
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lanc	id be in entail it seed of its seed of i		odman Sr.				ars Nama ary Mo		weiden Sumem	θ)		
Maryland 21215-0020	od 2 shou th and M 27 is man traumat	19e. Informant's Name/Ralationship (Frank Rogowski)			-			dale, M		_	Code)	
altimore,	Pages 1 av ent of Hea st: If Nem 3 ry or other	20a. Method of Disposition 1 ☑ Burial 2 □ Cramation 3 □ 4 □ Donation 5 □ Other (Specif	Removal from Stata	20b. Place of Disp cemetery, cre Ceda	osition (Neme of metory or other r Hill	f plece)	3-	Date -16-00	20c. Location - Brook	City or Tow Lyn, M	n, State	
alti	mit. postar y inju	21. Signature of Funaral Sarvice Licer		2	2. Nama and Ad			2				
ш	20118	1 DANDES	X Kell	+				neral He Ave. Ros		MD 1	21237	
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that ceused the	daath. Do not ar	nter the mode of	dying, such a	s cerdiac o	r respiratory arr	ast,	1	Approximate ntarval Between	
	Physician										Onsat and Death	
	/Medical Examiner	Immediata Causa (Final diseasa or condition	· M	Miana	nus	Lus	ne,	and	Pelin	ma	11.	
		rasulting in death)	Du	aligned e to (or/e/s a conse	quence %:		0					
	Z z		h							1		
	the death certificate be executed by the attending physician and sched for use as the bunal-transit hysician/Medical Examiner	Sequentially fist conditions,	Du	a to (or as a conse	quance of):							
60,	cian cian burial	Sequentially fist conditions, if any, leading to immadiata cause. Entar funderlying Cause (Disease or injury	c									
68760,	ficate be physicians the burners of	that initiated events rasulting in death) Last	Du	a to (or as a conse	quance of):							
	E B		d									
Box	eath ce attendi I for use clan/I											
o.	at the death ce by the attendi tetached for us Physician/	Part II. Other significant conditions o	ontributing to death but r	ot rasulting in tha	undarlying ceus	given in Part	14.	23b. Did to	obacco use cor	ntributs to t	the cause of death?	
0	v requires that the de been signed by the is should be detached leted by Physic	CAD, ASCVI	D, OVT	CHF,	De	ment	in	1 Y	'88 2 □ No	3 Proba	Unknown	
ords	iaw requires that as been signed b a 2 should be dete npleted by PI	anciter of	I nulla ina	an	mely			24a. Was a	n autopsy med?	avail	a autopsy findings lable prior to	
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æ	0 - 5 -							1□ Y	as 2 No	10	Yes 20 No	
ita	ystclan: The s certificate director, pag To Be Co	25. Wes case rafarred to medical				26. Plac	a of Deeth	(Check only or	ne)		,	
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o uoi	ith.: After this funeral	27. Mannar of Deeth 1 Natural 5 Panding 2 Accident invastigation	28a. Dete of Injury (Month, Dey Y	ear) 28b. Tima Injury		Injury at Work? 1 Yes 2		28d. Dascribe h	cribe how injury occurred			
Division of Vital Records,	tal or Attending P rs after death. at Director: After t led in by the funers Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, atc. (- At homa, farm, s Specify)	traat, factory, of	ice	1	28f. Location (S City or Tow	treet and Numb n, Stete)	er or Rural	Route Number,	
	To the Hospital or Atta within 24 hours after de To the Funeral Directo completely filled in by it Medical Certific	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of n niner: On the basis of ax and mannar state	aminetion and/or in								
	Vithin To the Compl	29b. Signatura and title of certifiar		STATE OF	29c. Lie	ansa number		2	29d. Data signe	d (Month, D	lay, Year)	
	->-0	marila of	almin d)	D	5451	0		3-1	5-0	00	
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0	Des	3007 NOMAR	n Muhhai	, bal	Ames O	Mn ~	2/2/	4				
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	Registrar	MAD 1 7 2000	rement /	19000	w							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08958 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death Month Phyllis M. Ridgeway March 13 2000 12:05 AM 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 42 Brookfield Road Pasadena Anne Arundel 5. Sociel Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Deys Months Hours 1 M 2 X F 72 Yrs. 216-20-6476 15 1927 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel Pasadena 1 ☐ Yas 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 42 Brookfield Road 21122 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Stetus 14. Race - American Indien, Black, White, etc. 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Year or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Programing Manager Tele-Communications 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Owen Schwatka Ester Lutz 19e. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Gwynn Muhl (daughter) 29 Brookfield Road, Pasadena, MD. 21122 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State March 16 1 Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Cedar Hill Cemetery 2000 Baltimore, Maryland 22. Neme and Address of Fecility Stallings Funeral Home, P.A. 3111 Mountain Rd., Pasadena, MD. 21122 that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest 23a. Part1. Enter the disease, or shock, or heart failure. List 3 nonthe Immediate Cause (Final diseese or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initialed events resulting in death) Last Due to (or es e consequence of): Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobseco use contribute to the cause of death? 1 Ves 2 No 3 Probably 4 Unknown 24b. Were autopsy findings evailable prior to completion of cause of death? 24e. Wes en autopsy performed? 1 Yes 2. 17 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Hospile Hospi 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Dete of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending Investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

Physician/Medical Be Completed by

Examiner

Physician

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Pages 1 and 2 should be nent of Health and Mental

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Department of Health a important: if hem 27 is any injury or other tran 2005.

Physician

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Baltimore, Maryland 21215-0020

P.O. Box 68760.

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Division of Vital

sician end bunal-transit The lew requires that the death certificate be axecuted physician s the buna 50 certificate the Hospital or Attending Physician: funeral After To the Hospital or Attendir within 24 hours after deeth. To the Funeral Director: Al filled in by

Medicai Certification: To 29a. Certifier 290. Signatury and titly of certifier

4 I Homlcide

completely 1

State Registrar

31. Dete filed (Month, Dey, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 1 7 2000

- doby M.D.

32. Registrer's Signeture

Tertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) and menner as stated.

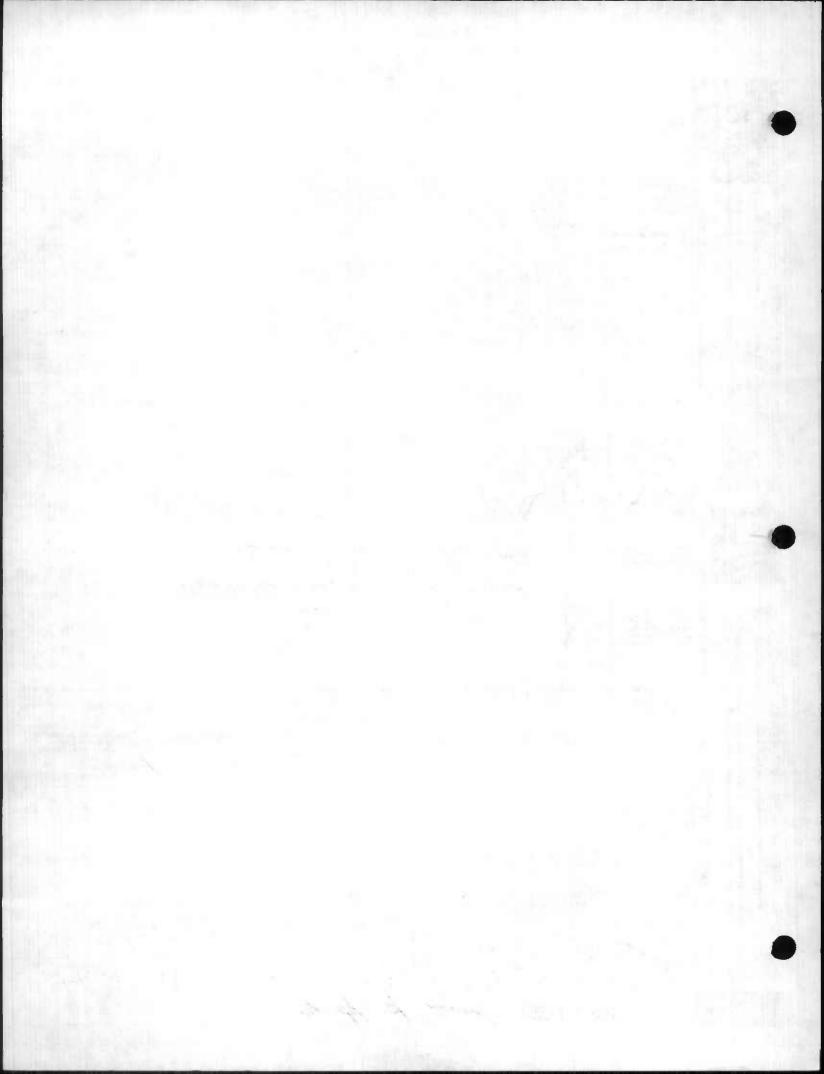
Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner steted.

29c. License number

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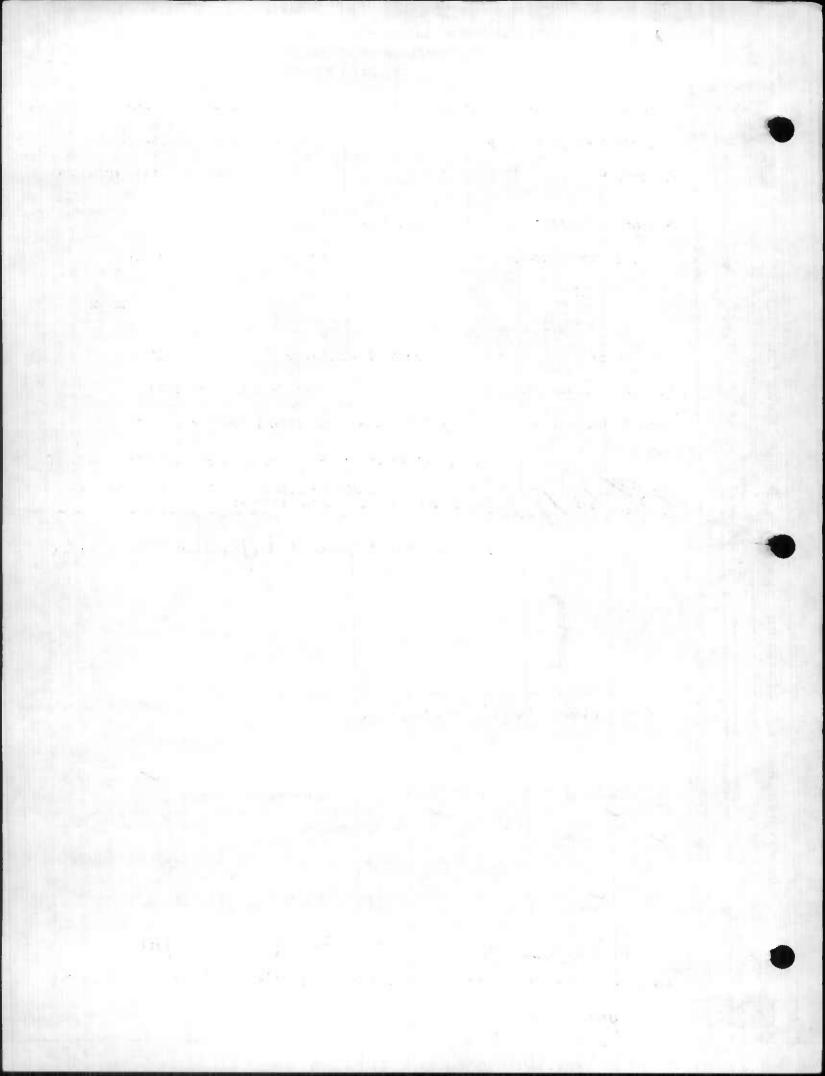
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Fodera Md. 21122



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	220-50-4928 Usual Rasidance of Decedant	1□ M 2 CkF	5	2 Yrs.	Months	Days	Hours		n, Day, T	1 1947		RYLAND
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	21. Signature of Fungeti Service		17	22	2. Nama a	and Addra	ss of Facility					
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	30. Nama and addrass of person	who completed ce	usa of death (Ita	m 23a) (Type,	Print)	ron	st- F	larre	De (Grace	Mo.	Rivr8
			De-Manda Di-			1						
State Registrar	31. Data filed (Month, Day, Year,	32.	Registrar's Sign		المر .	pau	61	(60.70		9		

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 16/112m meh /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number 4c. County of Death **Examiner** MARMANd BALLMINE
H Under 24 Hrs. 8. Date Ustems N/A Redicin If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiace (Stete or Foreign Country) **Funeral** Days Months M 2DF 82 178-05-5665 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28s-f show 1 Yes 2 No Director Harford Bel Air 10e. Street and Number 10f. Zio Code 10g, Citizen of What Country? 23a 871 Ellicott Drive 21015 USA Funeral 12. Wes Decedent Ever in U,S.
Amed Forces?
1 (2) Yes 2 □ No 1943
If Yes, Give
Yeer or Detes: 1945 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 8 1 Yes 2 No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Tool Designer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Department of Health and Mental Important: If Item 27 is marked o Harry Snyder Mary Arnold 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 871 Ellicott Dr., Ella L. Snyder/wife Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removef from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 03/16/00 Baltimore, MD 22. Name and Address of Fecility
Cremation Society of Maryland, Inc. 21. Signature of Euneral Service Licens 1 romas Thomas Gregor 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel ementa disease or condition resulting in deeth) **Examiner** Due to (or as a consequence of) Physician/Medical Examiner Theumanice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) signed by the at d be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No funeral director. 80 25. Was case referred to medical 26. Place of Death (Check only one) axaminer? 1 Yes 2 No Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Menger of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 1 Naturel 2 ☐ Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide

The law requires that the deeth certificate be executed P.O. Records,

altimore, Maryland 21215-0020

filed within 72

Pages 1 and 2 should be

certificate Division of Vital or Attending Physician: this After death. within 24 hours after deat To the Funeral Director: Hospital the the 0

Registrar

Medical

29e. Certifier (Check only one)

29b. Signeture end title of certifier

30. Name and address of person npleted cause of de ath (Item 23a) (Type, Prin Kole South

Registrar's Signal

29c. License number

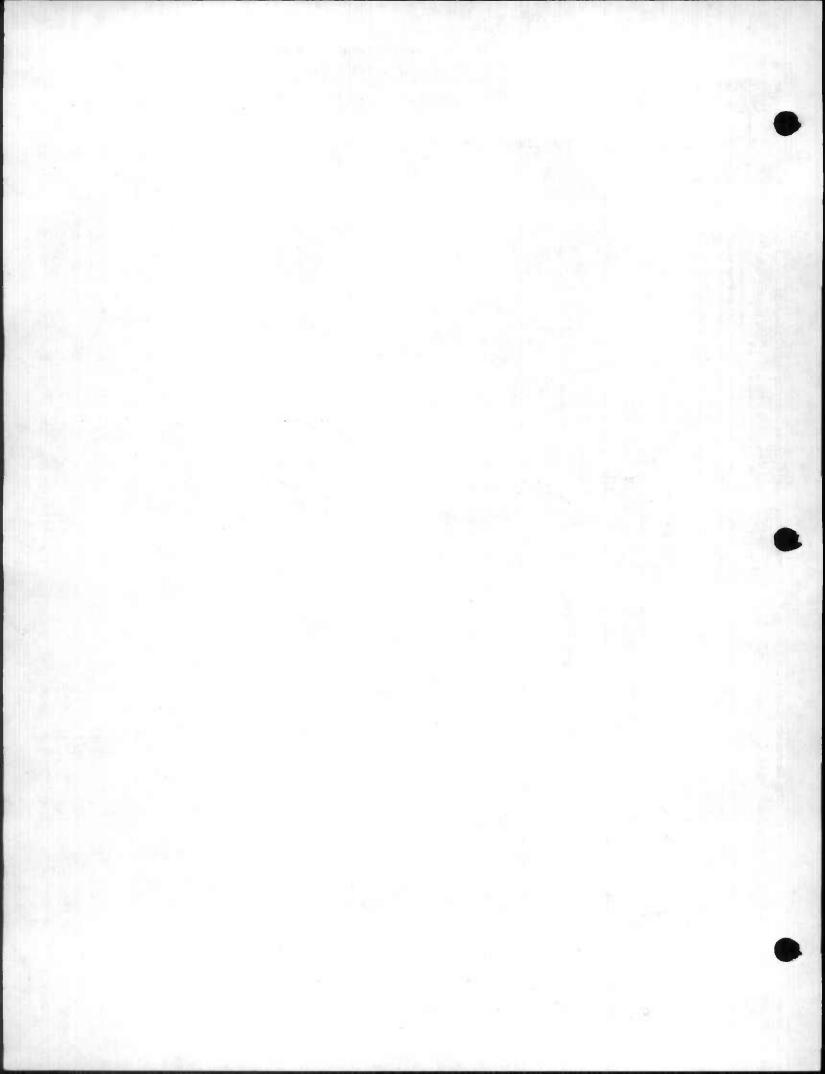
HMRL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 0130HRS PHILLIP SKEENS 2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE AG-NES OSPITAZ If Under 24 Hrs. Hours | Min. 5. Social Security Number 8. Dete of Birth (Month, Day, Year) July, 15 1917 9. Birthplace (State or Foreign Country) N. Carolina 7. Age (In yrs. last birthday) Days 180 M 2□ F Months Hours 243-16-1147 Usual Residence of Decedent 10a. Stata 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No N/A Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 907 Lafayette Ave 21216 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien 11. Merital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: Black 3 N Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Self - Employed 6 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Phillip Skeens, Sr Daisy Mills 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rurat Route Number, City or Town, Stete, Zip Code) 3617 Kings Point Rd Randallstown, MD Leroy Cox / Grandson 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐(Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 3-20-00 Chesapeake Crematory, Inc. Beltsville, MD 21. Signature of Funeral Service Licen 22. Name and Address of Fecility CAFA Stephen D. LChimmenn, P.A. 8717 Green Pastures Dr., Towson, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest shock, or heart tellure. List only one cause on each line. Approximete interval Between Onset and Death Immediate Cause (Finel 8 MONTHS OF THE LUNG CARCINOMA diseese or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributa to the cause of death? 1 ☐ Yaa 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to 24e. Was an autopsy performed? completion of cause of death? 2130No 26. Placa of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Anpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work?

Examiner hysician and the burial-transit the attending physician been signed by should be detac After after death

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

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r than "natural", or hama 23a or 28a-f the Medical Examiner must be notifi-

altimore, Maryland 21215-0020

Pages 1 and 2 should be filed of thrent of Health and Mental Hygis fant: If them 27 is marked other 1

Physician /Medical

> Physician/Medical p Completed 86 Certification: To

Medical

Examiner

25. Was case referred to medical axaminer? 1 Yes 2 No

29e. Certifier

5 Pending investigation Natural 2 Accident

6 Could not be determined 3 ☐ Suicide 4 Homicide

28e. Place of Injury - At home, ferm, street, tectory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

†S/Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated. 29b. Signature and title of certifier M.B

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NANA CEASAR,

900 CATON AVE BALTIMURE MD

Registrar

31. Dete filed (Month, Day, Year) 7 2000

32. Registrar's Signature

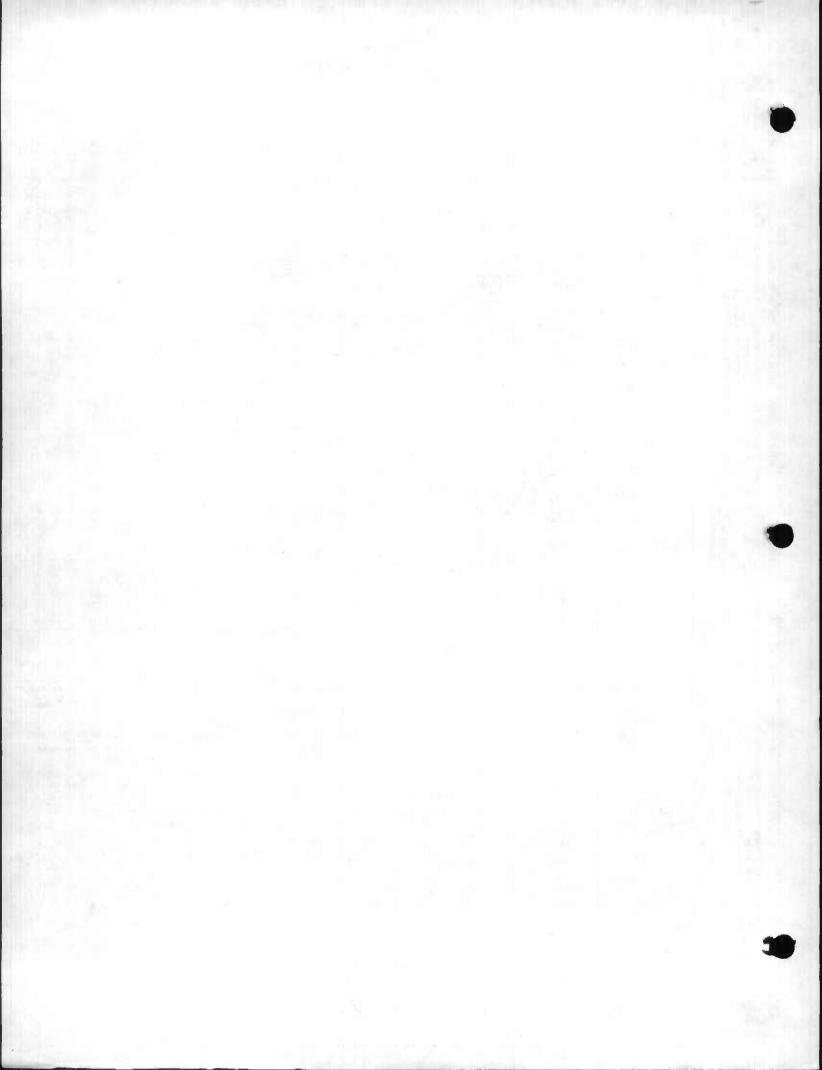
STAGNES HOSPITAL

To the Hospital e within 24 hours a To the Funeral D



State of Maryland / Department of Health and Mental Hygiene 00 08962

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Physician /Medical	Roslyn J.	Scott					March 1	6, 2000	Year	11:05 A.M		
Examiner	4a Facility Name (If not institution, g 1742 Abbotston S					Town, or Laltimo	ocation of Death	4c. County				
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Du *	Usuel Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location					1	0d. tnside City Limits		
Aaryle 1 sho	MD NA	-	Baltimo							XIXYes 2 □ No		
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21215-0020 d within 72 hours after death with the Maryland jiene. It than "natural", or items 23s or 28s-f show the Maryland for the mast on notified.	3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Examed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	ver in U,S. 1	3. Was Decedent If Yes, specify 0 1 ☐ Yes 2 🖸			ecify Yes or No- Rican, etc.)	Blac	14. Race - American Indian, Black, White, etc. Specify: Black			
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larylan 2 should be and Mental is marked o	19a. Informant's Name/Ralationship		19b Mr	ailing Address (Str	1		ral Route Number.			Code)		
re, Maryland 212 s 1 and 2 should be filed with! Health and Mental thygiene. If is marked other than other traumatic event, the M TO Be Comp	Mr. Kim A. Ric								imore, MD 21218			
Baltimore, N permit. Pages 1 and Department of Health Important: If item 27 any injury or other to	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Spec	ify)	cemetery, c	22. Name and Ad	place) Cemet dress of Fe	ecility Ba	03-21-2	000 A	nne ylan	wn, State MD. Arundel (d 21202		
Physician /Medical Examiner	23a. Part1. Entar the disease, or cor shock, or heart failure. List onl Immediate Causa (Final disease or condition resulting In death)	Arterio	he death. Do not on the death.	enter the mode of	dying, such	as cardiac	or respiratory arre		1	Approximate Interval Between Onset end Deeth		
dasth certificate be executed estending physician and offer use as the burist-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disaasa or Injury that intiliated evants resulting in death) Lest	С	ue to (or as a consue to (or as a cons									
P.O. BOX of the death ce d by the strendir etached for use Physician/	Part II. Other significant conditions	Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in P							23b. Did tobacco use contribute to the cause of			
4 40			1□ Ye	1 Yes 2 No 3 Probably 4								
aw requir							24a. Was ar perform	ned?	av.	ere autopsy findings ailable prior to mpletion of cause death?		
The late he page							1 Yes 2 No 1 Yes					
Vital Indian: The certificate rector, par	25. Was case referred to medical examiner?					lace of Dea	th (Check only one)				
Of Vita Physicism: this certific ral director,	TOYes 2☐ No 27. Manner of Death	-	t 2 ER/Outpat			Nursing Ho	ome 5 N Reside			y)		
ivision r Attending tar death. rector: After n by the fune	1 Datatural 5 Pending 2 Accident investigati 3 Suicide 6 Could not determine	De Place of Injur	Year) Injur	М	njury at Work? I∐ Yes 2	2 🗆 No	28f. Location (Str. City or Town	eet and Numb		nl Route Number,		
a men		hysician: To the best of miner: On the basis of a and mannar state	xamination and/or									
To the Ho within 24 I To the Fu completel	29b. Signature and title of certifier	CV		29c. Lic	ense numb	oer	29	d. Date signe	d (Month,	Day, Year)		
£ /-	> Mounte (The Trill			0.	C.M.E	. 1	March 1	6, 20	000		
9	30. Nama and addrass of person who Margarita Korel		ath (Itam 23a) (Typ		n Str	eet, I	Baltimore	e, Marv	land	21201		
State Registrar	31. Date filed (Month, Day, Year) MAR 1 7	2000 32. Registrar	's Signatura		K							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 15, Month **Physician** 2000 Regina Steadman March 2:05 AM Mary /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Eldercare - Cromwell Center Baltimore Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) ff Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 9, 1907 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□ M 2♥ F Montha Days Hours 92 Yrs. Director 219-03-7955 Maryland Usual Residence of Decedent d 2 should be filled within 72 hours after death with the Marylen th end Mentel Hygiene. 7 le merked other than "safural", or thems 23a or 28e-f ehow treumatic event, the Hidden and the marker must be notified. 10e State 10b County 10c. City. Town or Location 10d. Inside City Limits ₩ Yes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1651 East Belvedere Avenue #321 21239 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married 1 Yes 2X No Specify: Specify: White P 3 ☒ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) t6b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy, Important: if item 27 ie marked other any Injury or other treumatic event, I page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Anthony Stanley Parr Clara Estelle Gorsuch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9400 Dawnvale Road Mrs. Dolores Fisher / Sister Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗓 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Holy Redeemer Cemetery 3/17/00 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Timothy Harman 22. Name and Address of Facility Leonard J. Ruck, Inc. Funeral Home 5305 Harford Road Baltimore, MD 2 Baltimore, MD 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailule. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) CORONARY Examiner Due to (or as/a consequence of): Examine physicien end the burial-transit MENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) TENSION per Physician/Medical Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 Onknown þ 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 s 2 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? 8 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 110 Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 26d. Describe how injury occurred 1 DNaturat 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical

To the Hospital or Attenditional within 24 hours after deeth.

To the Funeral Director: A completely filled in by the fu

the death certificate be axecuted

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Box 68760,

P.O.

Division of Vital Attending Physicien:

with the Maryland

Baitimore, Maryland 21215-0020

State Registrar

DHMH 16 Rev 6/95

(Check only

Name and added

29b. Signature and title of certific

1841200144 190 3007 PULKUMAR 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 2000

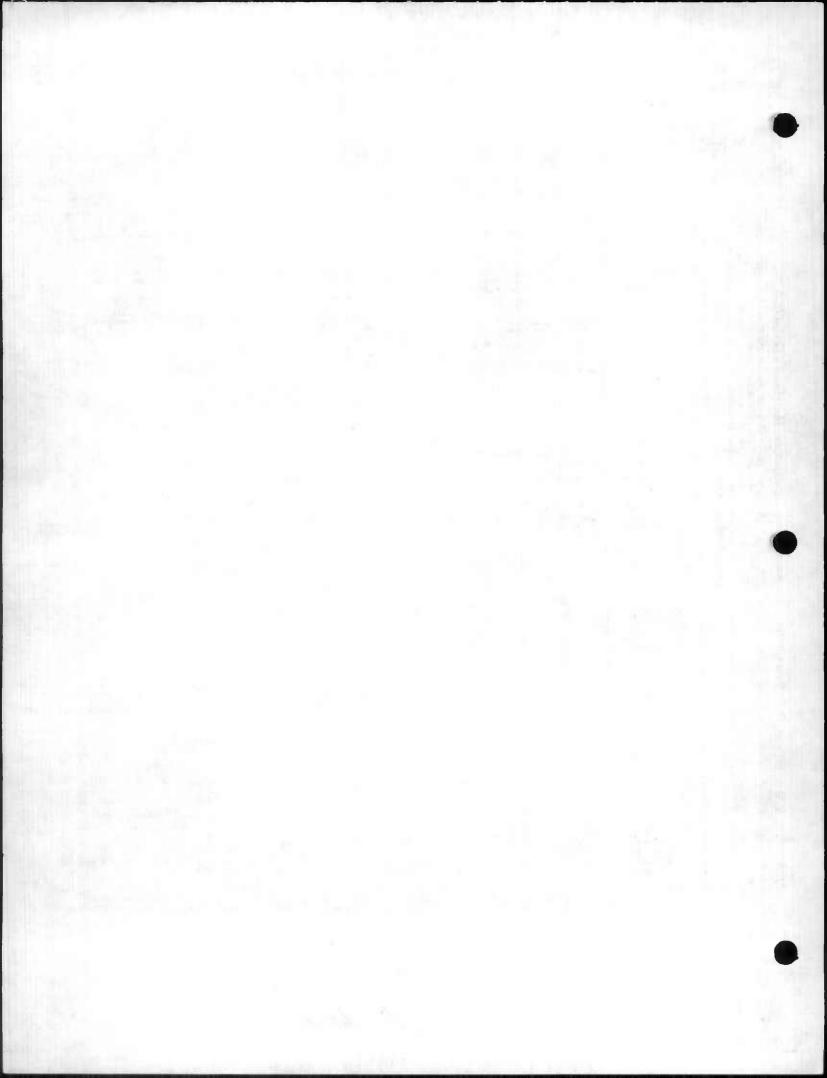
ss of person who completed cause of death (Item 23a) (Type, Print)

ENORTHERN PRWY RATIMORE, MD 21214

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number D52228 29d. Date signed (Month, Day, Year)

16 100



SUAREZ

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

AMEND ITEMS: #23 PARState of Maryland / Bepartment of Health? And Mental Hygiene AMEND#20B PER F.H. G781 3-17-2000 JAB

Certificate of Death Reg. No.

If Under 1 Year | If Under 24 Hrs.

Hours

Days

Physician /Medical

Miguel Angel Suarez

1. Decedent's Name (First, Middle, Last)

Month MARCH

12, 2000 12:20P.M.

Examiner

4a Facility Name (If not institution, give street and number) 14100 WEEPING WILLOW DRIVE

4b. City, Town, or Location of Death SILVER SPRING

2. Dete of Death

8. Dete of Birth (Month, Dev. Year)

4c. County of Death MONTGOMERY

Funeral Director

Nems 23s or 28s-f show

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filed within 72 hours effer Hygiene. ther then "neturel", or he

Peges 1 and 2 should be financial Mental I want of Meath and Mental I int: If Nem 27 Is marked of

permit. Peges 1 and 2 a Department of Health er Important: If Item 27 is eny Injury or other treu ands.

Physician /Medical

Examiner

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After

To the Hospital or A within 24 hours effer To the Funeral Direct Completely filled in by

Box 68760, certificate be

P.O.

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of Vital

Division Attending A hours effect des. Examiner

Physician/Medical

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Completed

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Certification: To

Baitimore, Maryland 21215-0020

Director

Funerai

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Completed

Be

10e State 10b. County MD Springfield

10c. City, Town or Location Silver Spring

Yrs.

7. Age (In yrs. last birthday)

04/12/1968 Puerto Rico 10d. Inside City Limits

10e. Street and Number

5. Social Security Number

078-64-6485

10f. Zip Code

Months

1 XYes 2 □ No 10g. Citizen of What Country?

Birthplace (State or Foreign Country)

11706 Georgia Ave. 12. Wes Decedent Ever in U,S.
Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 11. Marital Status Never Married 2 Married

6 Sex

1XM 20 F

 Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Specify: Puerto Rican 1 Yes 2□ No

20906

USA 14. Race - American Indian, Bleck, White, etc. Specify:

White

3 ☐ Widowed 4 ☐ Divorced

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Businass/Industry

Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)

College (1-4or 5+)

Unemployed 18. Mother's Neme (First, Middle, Meiden Sumeme)

In Jail

N/A

19a. Informant's Name/Relationship (Type, Print)

Carmen Santana 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Carmen Santana Mother

137 McNair Street Brentwood.

NY. 11717 20c. Location - City or Town, State

Bay Shore, NY.

20a. Method of Disposition

1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 □ Donation 5 □ Other (Specify)

20b. Place of Disposition (Name of cemetery, cremetory or other place) Oakwood Cemetery

3/17 03/18

21. Signature of Funeral Service Ligansee

22. Neme and Address of Fecility

Sterling Ashton Schwab Funeral Home, Inc.

23a. Pert1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, 21228 Approximate shock, or heart failure. Unit only one cause on each line. Intarval Between Onset end Death

Immediate Cause (Finel disease or condition resulting in death)

DOXEPIN INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Due to (or es a consequence of):

Due to (or as a consequence of)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Wes an autopsy performed?

24b. Were autopsy tindings evailable prior to completion of cause of death?

1 Yes 2□ No 1 ☐ Yes 2 ☐ No

25. Was case referred to medical axaminer? 1X Yes 2 No

27. Manner of Death 5 Pending investigation

6 ☐ Could not be determined

28a. Date of Injury FOUND. Day Year) 3/13/2000

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of P FOUND: M

28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)

Other: 4 Nursing Home XXResidence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred SUBJECT INGESTED DRUG

26. Place of Deeth (Check only one)

281. Location (Street and Number of Rural Route Mumber City or Town, State) 14100 WEEPING WILLOW DR. SILVER SPRING, MD.

1 Natural

2 ☐ Accident 3 ☐ Suicide

4 ☐ Homicide

FOUND AT HOME 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner es stated.

27 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated.

29c. License number O.C.M.E.

MARCH 13,2000

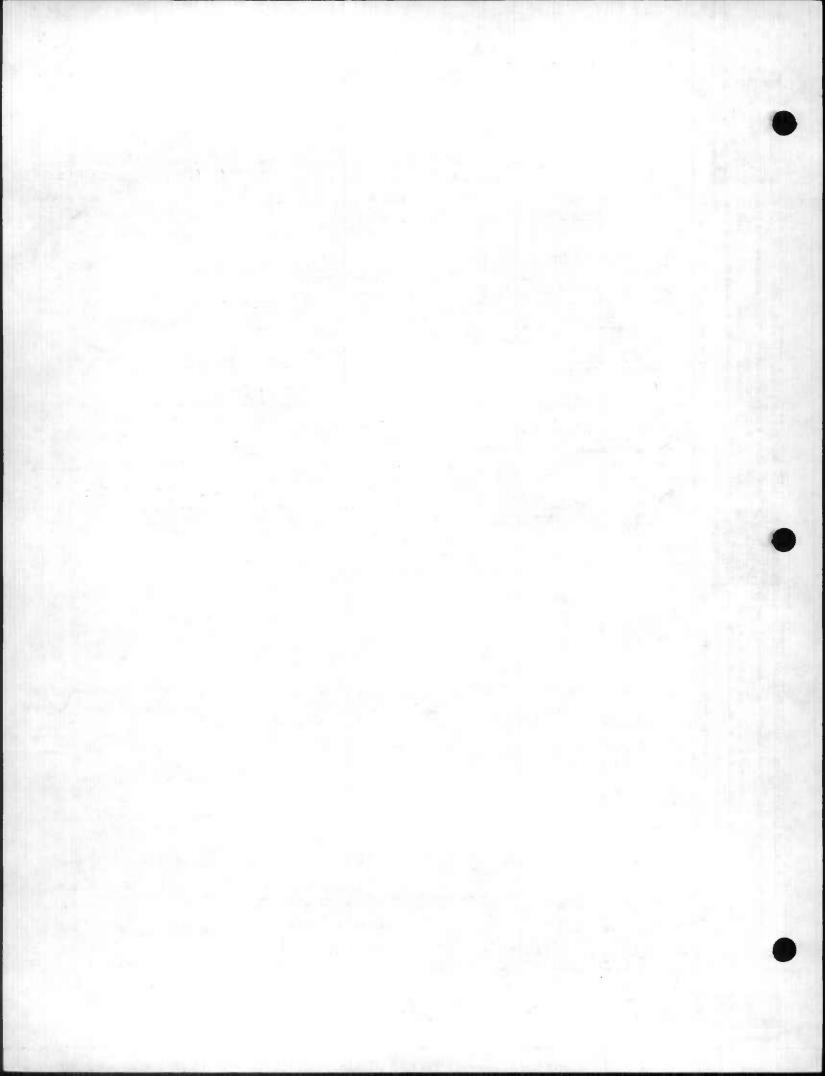
29d. Date signed (Month, Day, Year)

and address of person who com d cause of death (Item 23a) (Type, Print)

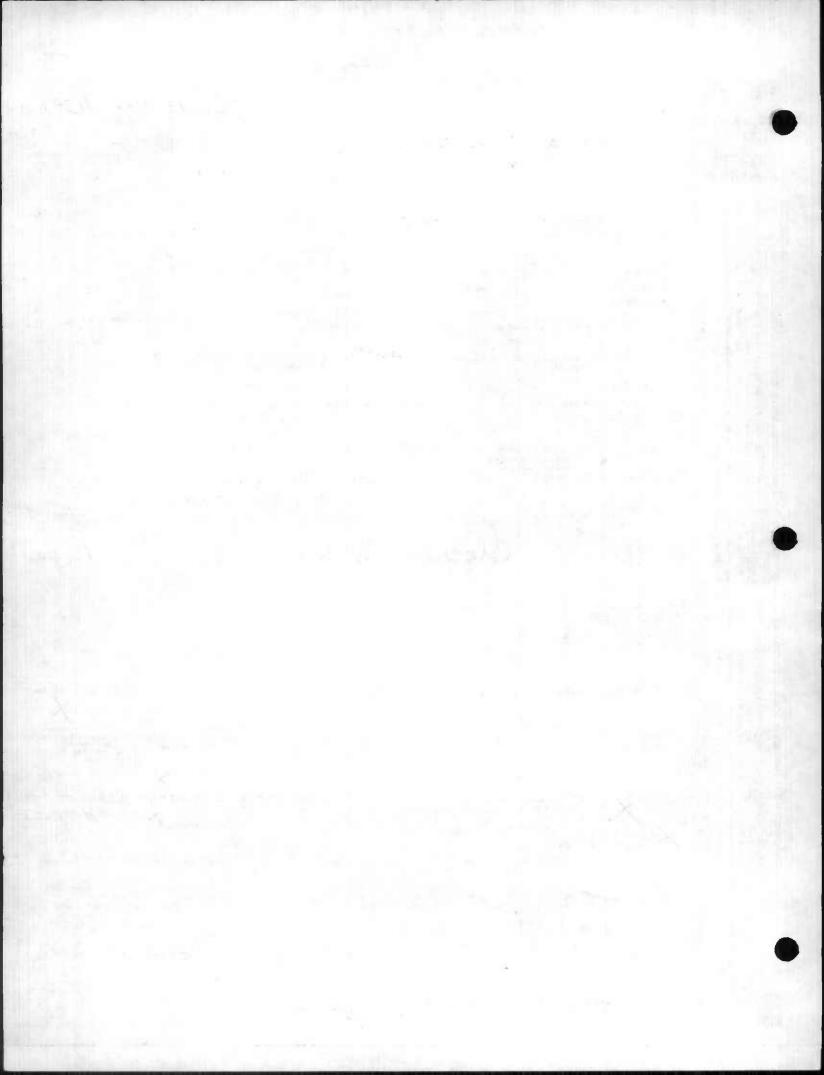
Hospital:

DAGDRIOD . KOROW MO 111 Penn Street, Baltimore, Maryland 21201

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Sonature MAR 1 7 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month **Physician** MARCH 5,2000 Betty Dean Stealy /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice/ Mercy Hospital <u>Fimonium</u> if Under 24 Hrs. Baltimore If Under 1 Year 8. Date of Birth (Month, Day, Year) 5. Sociel Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours 1 M 2 F Months Devs Director MD 212-22-0326 08/07/1924 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2000 Director 28a-f Baltimore Dunda1k 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? b 3141 York Way Nerna 23a 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetua 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 14. Race - American Indian Bleck, White, et 1 Never Married 2 Merried White Baltimore, Maryland 21215-0020 8 1 Yes 25 No Specify þ 3 Widowed 4 □ Divorced Yeer or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hygiens. 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) epartment of Health and Mental important: if them 27 is marked oil any Injury or other traument. Be Pages 1 and 2 should be nent of Health and Mental Ellie Worth Eva Trayer 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Jim Stealy Son 1951 Sue Creek Dr. Essex, MD. 21221 20a. Method of Disposition 20b. Plece of Disposition (Name of Dete 20c. Location - City or Town, State Gardens Of Faith 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 03/17 Overlea, MD. 4 □ Donation 5 ★Other (Specify) Entombmer: t 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Sterling Ashton Schwab Funeral Home, Inc. 736 Edmondson Ave. Baltimore, MD. 21228 23a. Pert1. Enter the director, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or bean factor but only one cause on each line. Approximate interval Between Onset and Death **Physician** Immediate Ceuse (Fine) disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequença of): Box 68760 Physician/Medical the Due to (or es e consequenca of): USB P.O. Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably To Unknown Records, p 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy parformed? certificate 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital or Attending Physician: funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one STE // A MARIS Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSDICE 2×100 Certification: To 1 Yes 1 Inpatient 2 ER/Outpaflenf 3 DOA this 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred Menger of Death 28b. Time of Injury 28c. Injury et Work? 5 Pending investigation Netural death. 1 Yes 2 No 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Pleca of Injury - At home, ferm, atreet, fectory, office building, etc. (Specify) filled in by 4 T Homicide To the Hospital 1 Perfliping Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner es stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner atated. Medical 29a, Certifier completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Defe aigned (Month, Dav. Year) 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) BAHIMORE. RISEBERG 7 2000 32. Registrar's Signature State Registrar



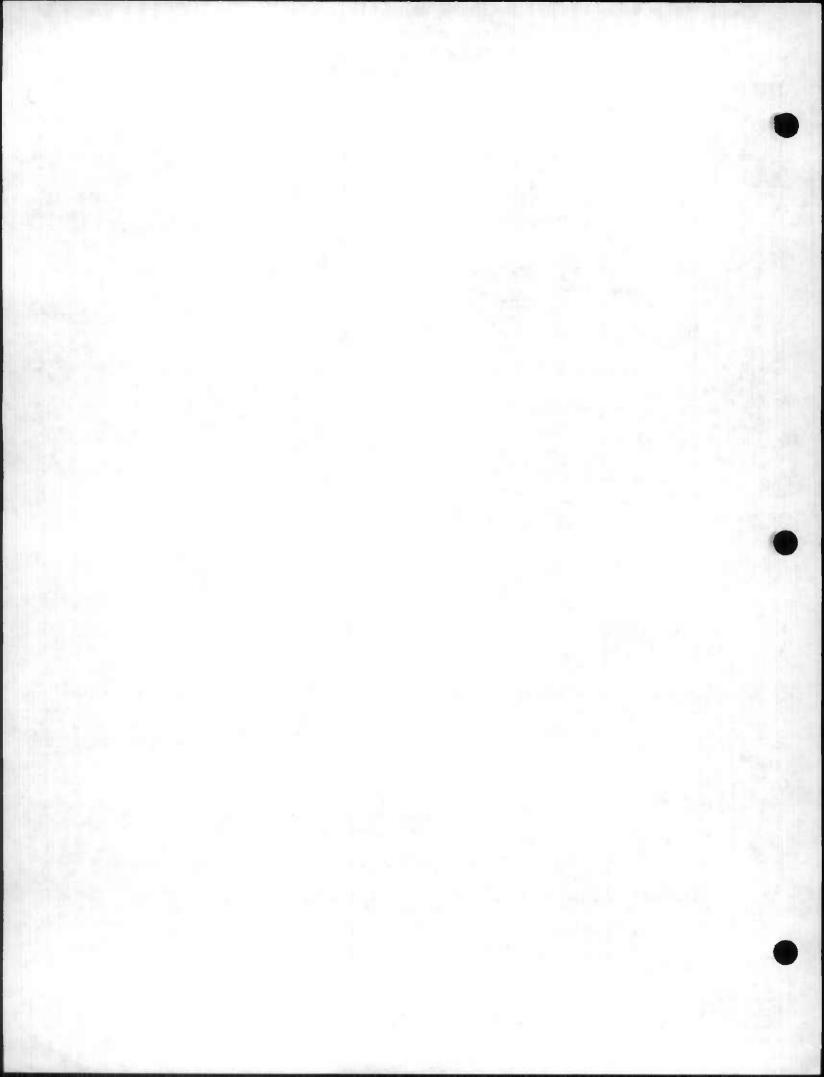
State of Maryland / Department of Health and Mental Hygiene

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FER	Cvach/Rosedale Funeral Home 1211 Chesaco Ave. Rosedale, MD 21237											,		
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s been signed by the attending 2 should be detached for use as pletted by Physician/Me	25. We exe 1 27. Mar 1 2 2 3 4 2 29e. C.(C) 0 29b. Si	s case referred miner? Yes 2 No No Nore of Death Natural Natural Accident Suicide Homicide artifler 18 heck only 2 ne) gnature and title	to medical 5 Pending Investigation 6 Could not be determined Certifying Ph Medicat Exam of certifie	Hospitei: 1 ☐ Inpa 28a. Dete of In (Month, D) 28e. Piece of I building, (yelclan: To the besi	tient 2 E iury ley Year) njury - At hometic. (Specify) t of my know of examination staled.	ER/Outpatie 28b. Time Injury me, farm, s ledge, dee on and/or it	ent 3 to of M M treet, factor th occurrence tigation 2:	28c. Inju	26. Place ther: 4 Nury at ork? Yes 2 Stime, date el opinion, des enumber	e of Death ursing Ho I No Ind place, ath occurr	1 Yes A yes a perform 1 Yes Yes A ye	n autopsy med? es 2 No nes 2 No n	3 Pro 24b. Way occ of 11 her (Speciated ber or Run anner as and due to and (Month,	lere autopsy valiable prior ompletion of odeath? Yes 2 fy) All Route Numer Stated. o the ceuse(ii)

ORIGINAL

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death dent's Name (First, Middle, Last) 2. Date of Death lave ,200C or Location of Death Name (If not institution, give street and number) 8. Dete of Birth Month, Day, Year, 6. Sex 9. Birthplace (State or Foraign Country) 7. Age (In yrs. last birthday) Days Months Yrs. 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 14. Race - American Bleck, White, etc Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status - American Indian 1 Never Married 2 Married FRICAN 1 Yes 2 No 3 ☐ Widowed 4 ☐ Divorced WAR 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry condary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) s Neme (First, Middle, Maiden Šumame) 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, 20a. Method of Disposition 1 Burial 2 DiCremation 3 Removal from State 4 Donation 5 Other (Specify) 20c. Location City or Town, Stete 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 43. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errast, shock, or heart failure. List only one cause on each line. BOUT MOTE MD 2/2/7 Approximate Interval Batween Onset and Deeth Immediate Cause (Final disease or condition resulting in death) Cardinasiala Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events enertra that initiated events resulting in death) Last Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco usa contributa to the causa of death? 3 Probably Unknown 1 ☐ Yaa 2 ☐ No 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 XN0 1 Yes 2 No 25. Wes casa referred to medical examiner? 26. Place of Deeth (Check only one) 1 Yes 2 Yo Other: 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Sasidence 6 □Other (Specify)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

8 Nerrie 23s.

natural, or

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens important; if health and Mental Hygiens than any Injury or other traumatic.

Baltimore, Maryland 21215-0020

Physician/Medical Examine Completed by Certification: To Be

27. Manger of Death

1 2 Natural 2 Accident

3 Suicide

29b. Signature and ti

29a. Certifier

4 Homicide

Box 68760. P.O. Division of Vital Records, page 2 a this After or Attending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun.

> State Registrar

edical

31. Date filed (Month, Day, Year) MAR 1

5 Pending investigation

6 Could not be

23

Date of Injury (Month, Day Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cosno 32. Registrar's Signature

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Yes 2 No

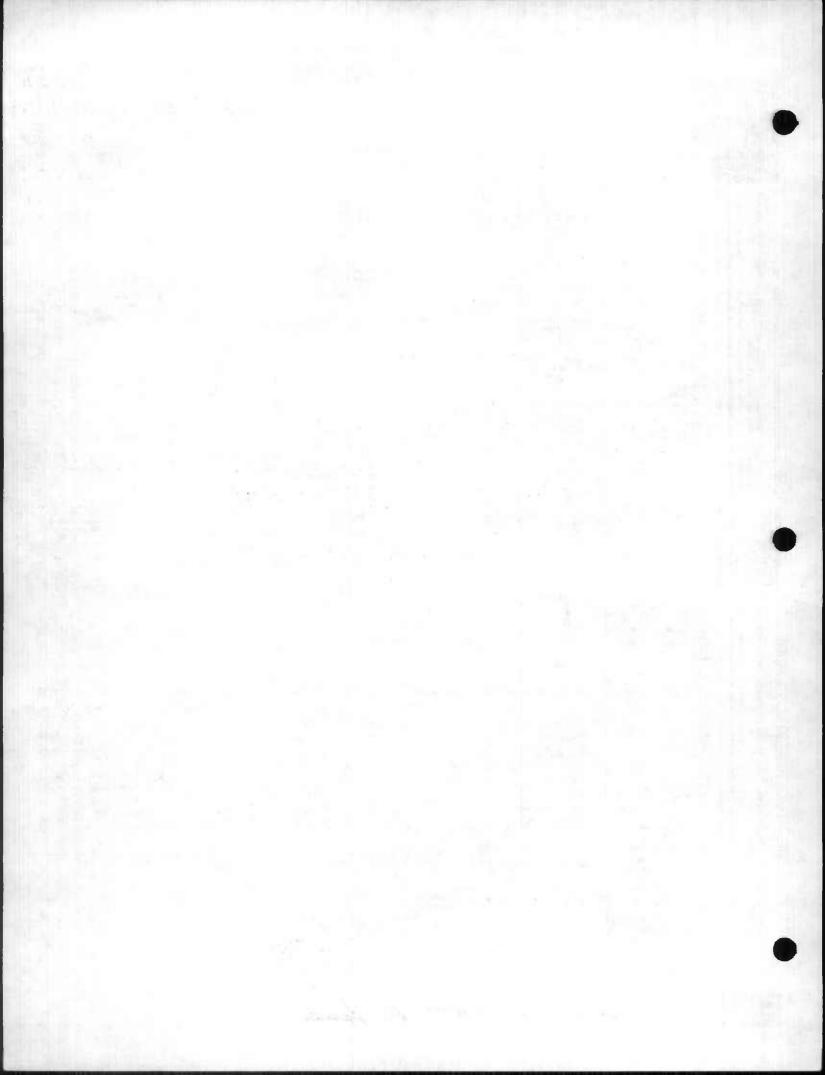
28c. Injury at Work?

The Continue Physician: To the best of my knowledge, death occurred at the time, data end place, and due to the cause(s) and manner as stated.

If the death occurred at the time, data and place, and due to the cause(s) and manner alained. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Dascribe how injury occurred



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day Month Year LeRoy Smith March 16, 2000 11:22am 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Ellicott City 4953 Brampton Parkway Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours XIX M 2 F 580-01-3296 81 Yrs. May 2, 1918 St. Thomas, VI Usual Residence of Decedent 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Howard Ellicott City MYas 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4953 Brampton Parkway 21043 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, Whita, atc. 1 Yes 200000 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yas XXNo Specify: Black. Specify XXWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Entrepreneur Real Estate 12 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Abraham Alexander Smith Alice M. Norman 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) LeRoy V. Smith / Son P.O. Box 2028 Saint Thomas, VI 00803 20a. Method of Disposition 20b. Plece of Disposition (Nama of cematary, crematory or other place) Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata Western Cemetery March 23, 2000 St. Thomas, VI 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Victor P. Doda 22. Nama and Address of Facility Charles L. Stevens Funeral Home, 1501 East Fort Avenue, Baltimore MD 21230 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heart feiture. List only one cause on each limit. Approximata Intarval Between Onset and Death CARDIOMYOFATHY ISCHEMIC Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): ARTERY 10TRS CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown PERIPHERAL VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2000 1 ☐ Yas 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4☐ Nursing Homa 5至Xesidence 6 ☐ Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation XXNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide

nding physician and use as the burlei-transit The law requires that the death certificate be axecuted Box 68760, algned by a certificata has t director, page 2 s director, Sign of

Physician/Medical Examiner þ Completed Attanding Physician: B 2 edical Certification:

Physician

/Medical

Examiner

MD

Director

Funeral

P

Completed

8

Funeral

Director

r than "natural", or items 23s or 28s-1 show the Medical Exercises must be natibled at

death

72 hours after

ified within 7 I Hyglene. Other then "n

permit. Pages 1 and 2 ahould be filled wh. Department of Heelth end Mentel Physiem Importants if Item 27 ie marked other tha any Injury or other traumatic event, that ones.

Physician

/Medical Examiner

altimore, Maryland 21215-0020

P.O. Records, Vital to al or Attanding Physical arter deeth.

I Director: After this of in by the funeral d Division To the Hospital o within 24 hours aff To the Funerel Di completely filled in

INOMAS 31. Data filed (Month, Day, Year)

4 ☐ Homicide

29b. Signature and title of-eartifier

29a. Certifier

MM

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

29c. License number 24740 29d. Data signed (Month, Day, Year) March 16, 2000

Location (Street and Number or Rural Route Number, City or Town, Stata)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A- TRAILL

HOPKINS TOHUS

BALTIMORE HOSFITAL

MD 21287

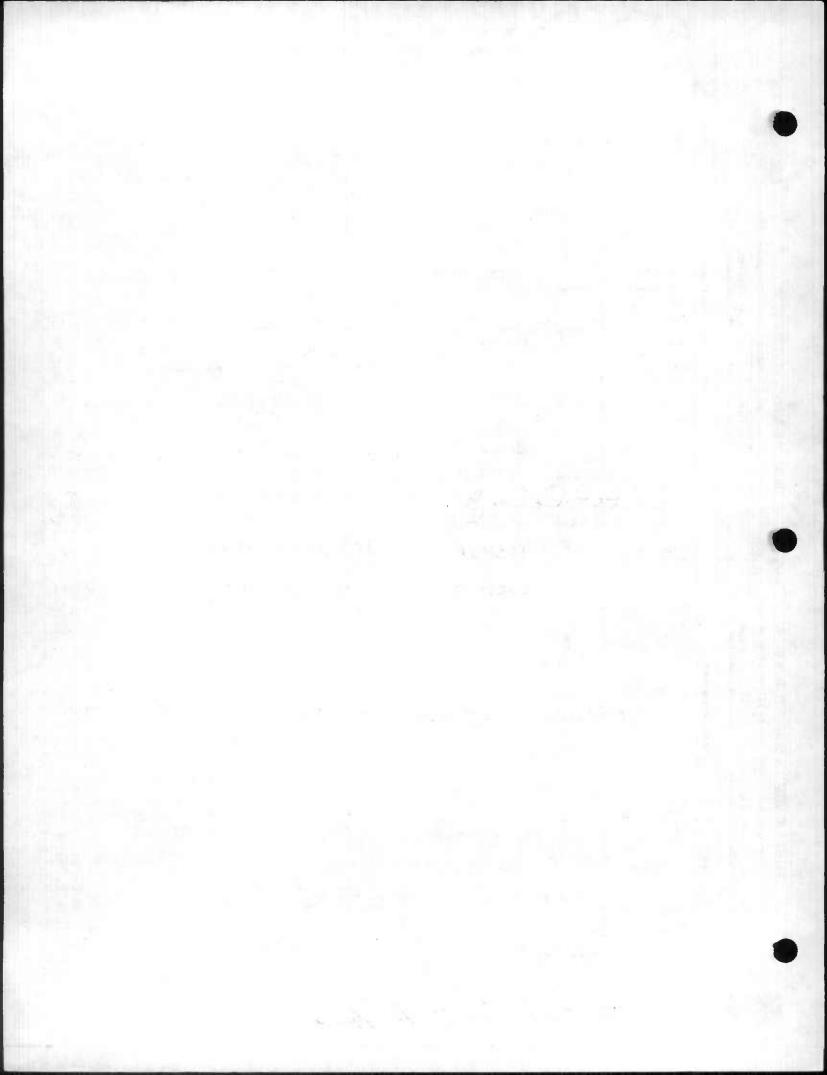
State Registrar

MAR 1 7 2000

32. Registrer's Signatura

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.



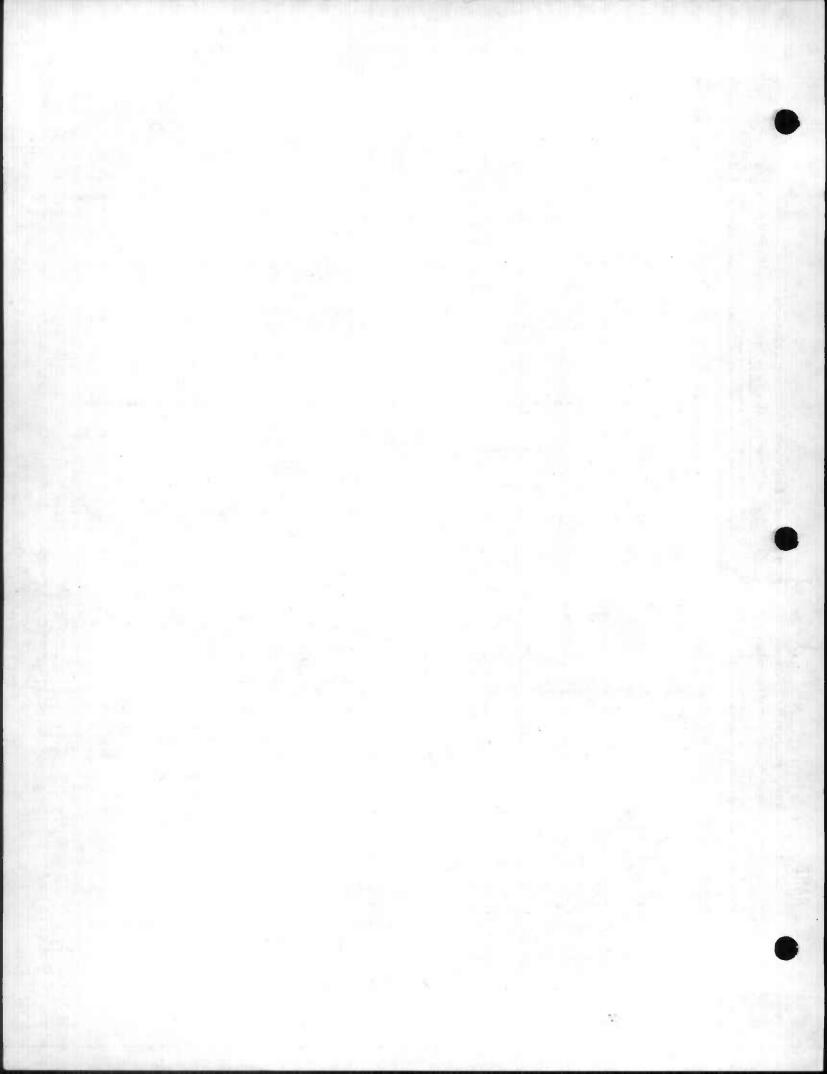
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Virginia Lee Tedrow W 2000 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner more Ba 8. Date of Birth (Month, Day, Year) If Under 24 Hrs If Under 1 Yea 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Deys Hours 212-34-8488 1 M 2 F Months 63 1936 Maryland Director **Usual Residence of Decedent** 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at Baltimore 1 ☐ Yas 2 ☐ No Directo Catonsville 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 801 Winters Lane, Apt. 430

11. Marital Stalus

1 Never Married 2 Married
3 Widowed 4 Divorced

12. Wes Decedent Ever in U.S. Amed Forces?
1 Yes 2 1 No If Yes, Give Year or Dates: 21228 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 72 hours after Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White PY Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Department of Health and Mentel Hyglene. Important: if item 27 is marked other than "nat, any injury or other traumatic avent, the Medical page. Elementary/Secondary (0-12) College (1-4or 5+) Bartender Bar 18. Mother's Name (First, Middle, Maiden Surname) 17, Fether's Name (First, Middle, Last) Ernest Duvall Lillian Bertha Judy 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ernest K. Tedrow/son 7136 Stone Throw Way, Elkridge, MD 21075 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stete Metro Crematory, Inc. 3/17/00 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD 21. Signature of Foneral Service Licensee ²²Name end Address of Facility Cremation Society of Maryland, Inc. Thomas Gregor 299 Frederick Rd. Baltimore, MD 21228 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** Kepp Vatory bailure days /Medical Immediate Cause (Finat disease or condition resulting in death) 28-Capneic Examiner Pulmonary Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Supraventricular Tachycand memia Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yes 2 No 1 □ Yes 2 □ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 2 ER/Outpatient 3 DOA 28c. Injury et Work? 27. Manner of Deat 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 8 24 hours Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

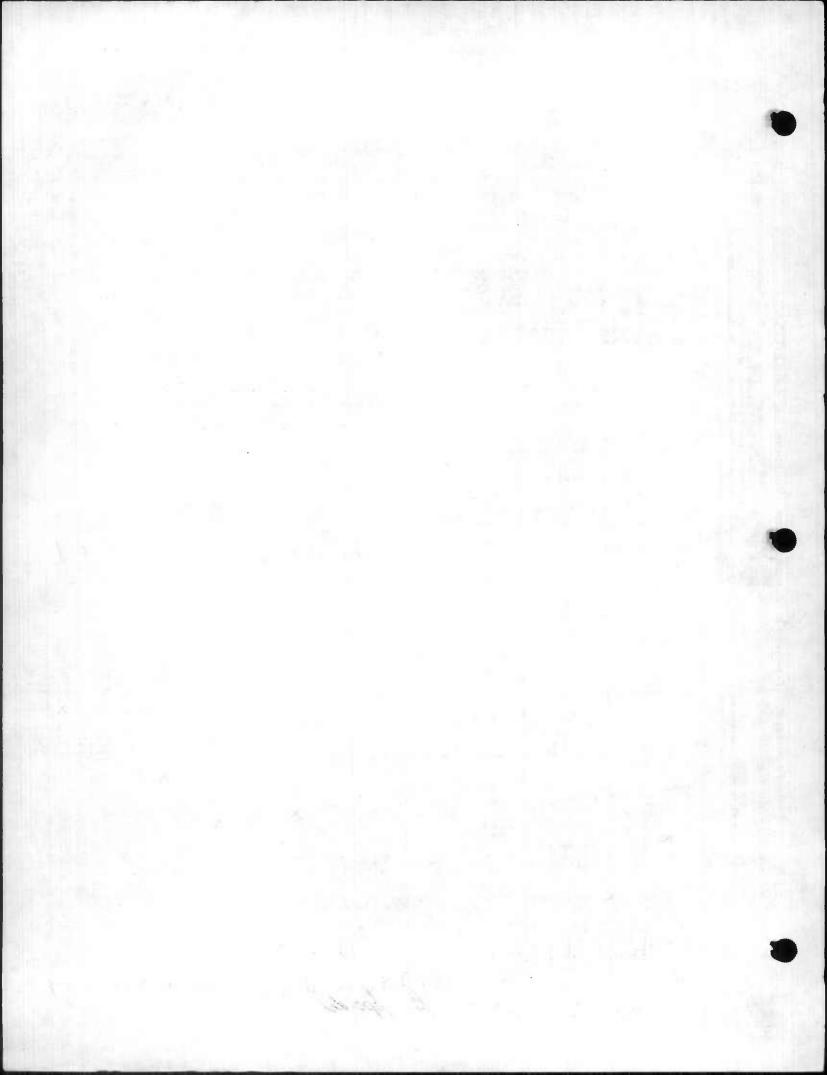
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the A 29b. Signature and the certifier 29c. License number 29d. Date signed (Month, Day, Year) 16 d cause of death (Item 23a) (Type, Print) etta hawn treneme (aton 31. Date filed (Month, Day, Year) 32. Registrar's Signeture State 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Sally N. Torrence 13 2:40 pm March 2000 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Crofton Convalescent Center Crofton Anne Arundel If Under 1 Year 8. Date of Birth (Month, Day, Year) May 17,1909 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 579-22-3874 90 Director North Carolina Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Marylai 28a-f show 1 ☐ Yes 2 No Director Anne Arundel Odenton 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 "natural", or hams 23s. 2401-K Forest Edge Court 21113 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces?
1 Yes 20 No If Yes, Give 14. Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. Wher then "natural", or its 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 200 Specify: Specify: White 3 3℃Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filled w.
Department of Health and Merital Hygien, important; if Item 27 is marked other the any Injury or other traumette event, the stops. Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be William Thomas Nantz Alice F. Blackwelder 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Cecil G. Torrence, Jr. (Son) 1002 Doublegate Road, Davidsonville, MD 21035 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 03/16/ 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery 2000 Brentwood, MD 21. Signature of Funeral Service Licens 22. Name end Address of Facility Hardesty Funeral Home, P.A. 23a. Pert1. Enter the disease, or complications that caused the deeth. shock, or heart feiture. List only one cause on each line. 12 Ridgely Avenue, Annapolis, MD 21401 Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between Onset and Death Physician /Medical Immediata Causa (Final veilmo norax disease or condition resulting in death) 01 Examiner Due to (or as a consequence of) Examiner physician and the burial-transit that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai Due to (or as a consequence of): 1000 P signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. P 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of deeth? irector, page 2 a 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Attanding Physician: 25. Wes case referred to medical Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 25 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 5 Pending 1 Naturat death. 1 Yes 2 No To the Hospital or Attandit within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident investigation 6 Could not be 3 Suicide Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29e. Certifier (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) pleted cause of death (Item 23a) (Type, Print) Hung Gambrills 1438 Dex ense 31. Date filed (Month, Day, Year) MAR 1 7 2000

Registrar **DHMH 16 Rev 6/95**



State Registrar

DHMH 16 Rev 6/95

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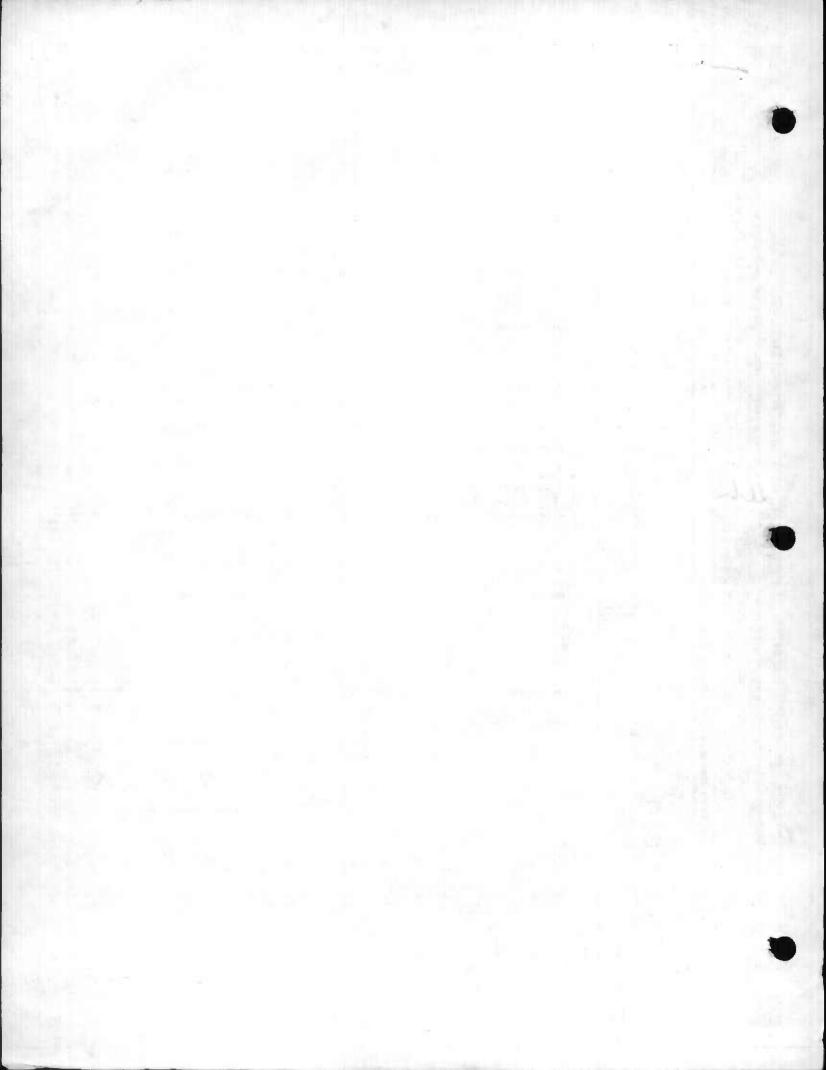
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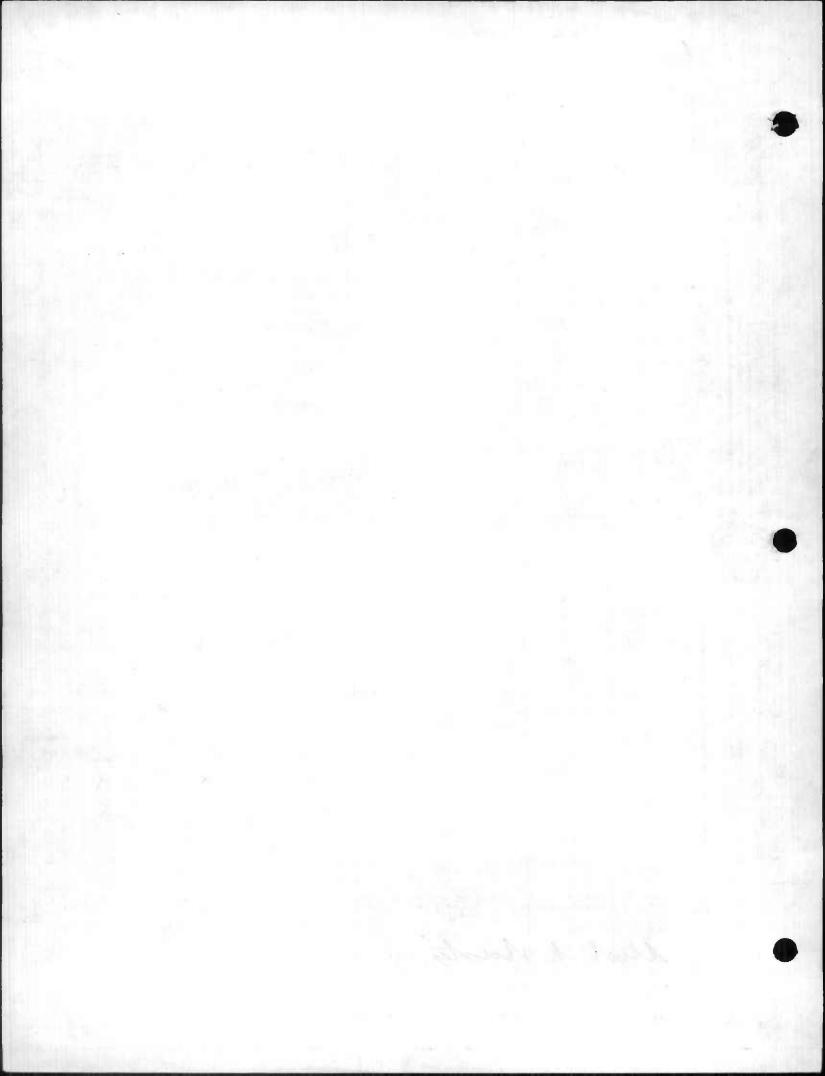
FEBRUARY 12,2000

111 Penn Street, Baltimore, Maryland 21201



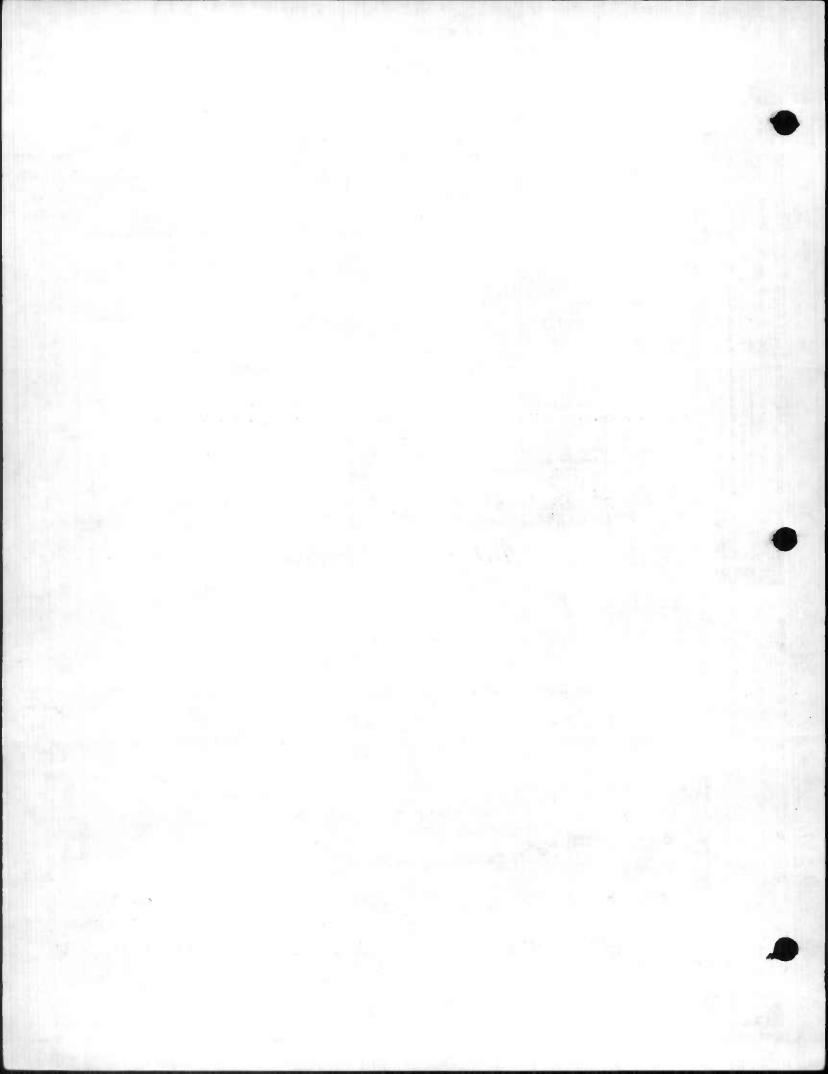
00-1499-027 R κ ς Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

Physician	1. Decedent's Name (First, Middle, L		io continua			2. Dete of De Month	ath Dey	3. Time of	
/Medical	Frantina M.	Vaughn				MARCH	14, 200	00 094	
Examiner	4a Facility Name (If not institution, g 7210 EDENBROOK			46	COLUM	or Location of Deat BIA	4c. County		
Funeral Director	173-40-6379	Sex 1 M 2 SF 7. Age (In yrs.	10 Yrs. If Under Months	or 1 Year Days	Hours A	fin. 8. Date of Bir Month, Da Sept. 2	Year 1949	9. Birthplaca (Stete of Country) Pennsylvar	
28a-f ahow notified at	Usual Residence of Decedent 10a. State 10b. County Maryland Howard		ty. Town or Location					10d. Inside Ci	
0 4 0	10e. Street and Number 7210 Edenbrook D.		ive B-102 101. Zip Code 21046					That Country? States	
ar, or the		12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		edent of His ecify Cuban 212 No		(Specify Yes or No Juerto Rican, etc.)	No- Bleck, White, etc. Specify: Black		
ygiene. er then "neturel", or he r, the Medical Exemina Completed by Fu	15. Decedent's (Specify only highest g	Education rade completed) College (1-4og 5+)	16a. Decedent's Usi (Give kind of w life. DO NOT Supervi	ork done du use retired)	tion uring most of	working	16b. Kind of Bu	siness/Industry	
f Health and Mental Hyglen fem 27 is marked other th other treumatic event, the TO Be CON	17. Father's Name (First, Middle, Las Sherman J. Washi	ington			Chris	tina V. G	•		
of Health and Rem 27 le m r other treum	19a. Informant's Name/Relationship Lindburg Vaughn		7210 Eden			B-102 C		State, Zip Code) , MD. 21046	
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sician and burial-transit	disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	a. Due to (c) 1 1 1 1				
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(Check only one) Check only one) Check only one)	7	To the Hospital or within 24 hours aft. To the Funeral Dir completely filled in Medical Cert		1⊠ Certifying 2□ Medical E	examiner: On the ba	sis of axamina	owledge, deat ation and/or in	h occurred et the ti vestigation, in my	ime, date and place, opinion, death occur	, and due to tha red at the time,	cause(s) and m	nannar as s	itated. o the cause(s)	
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D3V652 Many 12, 2000		- > - 0	•	AN	MD			D31/	452		Marih	12	2000	
30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)		3	- 1 -	4 1	/1			Print)		May 1	and	2101	y	
State Registrar State Registrar	T			- 10		egistrar's Sign		Spork	at at	7 11		101	/	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08974 Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Month Vest **Physician** Whee 2000 12:02 PM /Medical reet end number) 4c. County of Dea 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give st **Examiner** Bayview Johns Hopkins Bettin If Under 24 Hrs. 8. Data of Birth (Month, Day, 7. Aga (In yrs. last birthday) 5. Social Security Number If Under 1 Yae Birthplace (State or Foreign Country) **Funeral** Months Devs 212-32-3273 1MM 2□ F Hours 67 JAN 5,1933 Director MARYLAND Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow must be notfied at MD N/A BALTIMORE 1 X Yes 2 No Director 288-1 2 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 815 S. CONKLING STREET 21224 U.S.A. Nems 23s Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11. Marital Status Bleck, White, etc. 72 hours after 1 Yes 2 No 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 ☐ Yes 2 ☑ No Specify: Specify: by WHITE 3 ☐ Widowed 4 ☑ Divorced Year or Dates: Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Hygiens. College (1-4or 5+) MACHINIST WESTERN ELECTRIC Pages 1 and 2 should be Illed vent of Health and Mental Hygie int: if hem 27 is marked other 1 17. Father's Name /First Middle Last! 18. Mother's Neme (First, Middle, Maiden Surname) 88 EDWIN WHELLER EVA GOSMAN 19e. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) BRENDA DARLENE WHEELER -DAUGHTER 815 S. CONKLING STREET BALTIMORE, MD 21224 20b. Plece of Disposition (Name of cemetary, cremetory or other plece) 20c. Location - City or Town, Stete 20a. Mathod of Disposition Date 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) BROOKLYN PARK, MD Important: I any injury o CEDAR HILL CEMETERY 3/20/00 21. Signature of Funeral Service License 22. Name end Address of Facility MOOGEN CHARLES S. ZEILER & 6224 EASTERN AVENUE SON, INC. BALTIMORE, MD 21224 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. Approximeta Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Final Massive Gastra disease or condition rasulting in death) Examiner Physician/Medical Examiner no ance Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Dua to (or as a consequence of): Box 68760. Due to (or as a consequence of) P.O. Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobecco use contribute to the cause of death? been signed by t should be detact No 3 Probably 4 Unknown Records, py Completed 24b. Were autopsy findings available prior to 24a. Wes an autopsy performed? completion of cause of death? 1 Yes 2010 1 ☐ Yas 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director; After the funeral director; It is the funeral director di 8 25. Wes casa referred to medicat examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) edical Certification: To 1 Nes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 30x00A 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Neturel 5 Pending investigation 1 Yes 2 No 2 Accidant 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 3-16-02 41665

THE

DHMH 16 Rev 6/95

State

Registrar

3701 EASTERN AVENUE

BALTIMORE, MD 21224

completed cause of death (Item 23a) (Type, Print)

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32. Registrer's Signeture

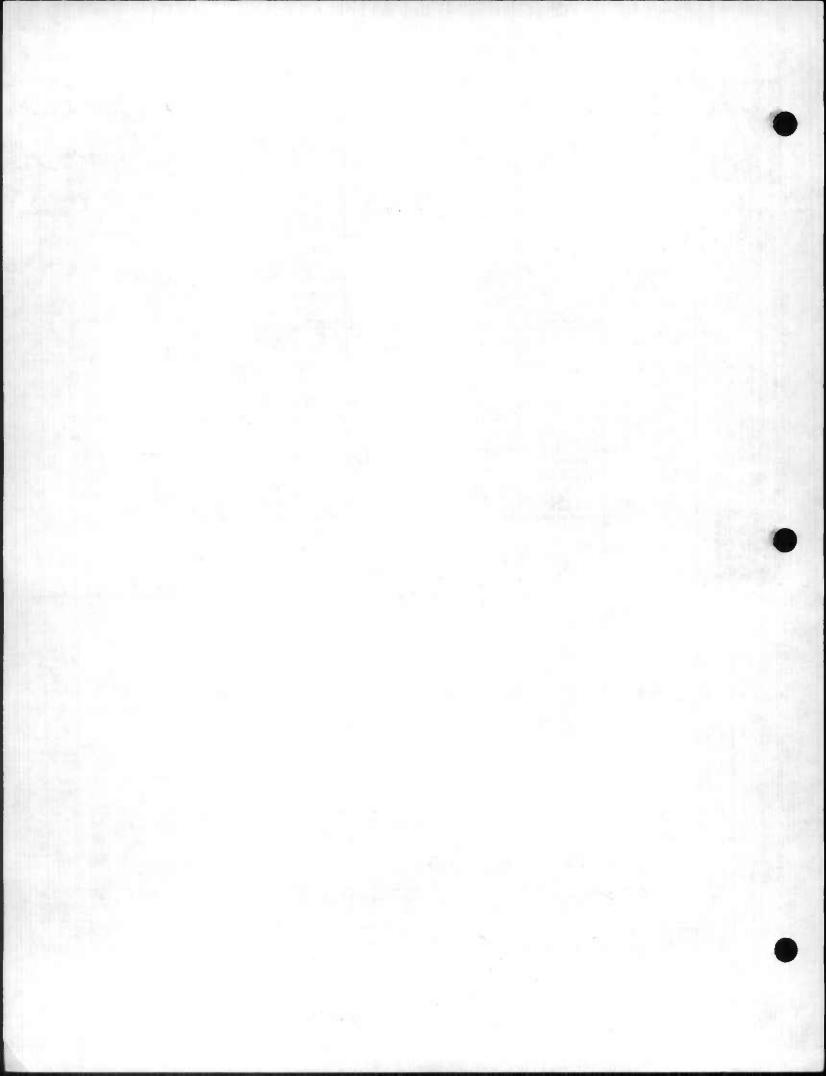
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31. Dete filed (Month, Day, Year)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 08975 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Winth Month Year Dive 14 1027 PM 2000 March 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Baltimore Hospital Johns Hopkins If Under 1 Yaar If Under 24 Hrs. Months Days Hours Min. Birthplaca (Stata or Foraign Country) 7. Aga (In yrs. last birthday) 5. Social Security Number 6. Sex 8. Data of Birth (Month, Day, Year) May 30, 1924 Days 1□M 2♥F 75 212-20-4565 Maryland Usual Rasidanca of Decedant 10a. Stata 10b. County 10c City Town or Location 10d. inside City Limits 1 X Yas 2 No Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 403 N. Belnord Avenue 21224 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☒ No If Yas, Giva Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 1 Nevar Married 2 Married 1 ☐ Yas 2 ☑ No Specify: Specify: If Yas, Giva Yaar or Datas: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Collega (1-4or 5+) 12th grade Homemaker Own Home 18. Mothar's Nama (First, Middle, Maiden Sumama) 17. Fathar's Nama (First, Middla, Last) Albert A. Wakefield Mary Pinkus 19a. informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) Thomas F. Wirth (Husband) 403 N. Belnord Avenue, Baltimore, MD 21224 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 Donation 5 Dothar (Specify) Entombment Oak Lawn Cemetery 3/18/00 Baltimore, Maryland 22. Nama and Addrass of Facility Schimunek Funeral Home, Inc. 21 Signature of Funeral Service Licensee Buan 3331 Brehms Lane. Baltimore, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate intarval Between Onsat and Death Immediata Causa (Final Shock nours disaasa or condition rasulting in daath) hours ected Sequentially list conditions, if any, laading to immadiata cause. Entar Underlying Cause (Disaasa or Injury that initiated avants rasulting in daath) Last Due to (or as a consequanca of) Dua to (or as a consequence of): Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown cord injury with quadraporesis 1 Yaa 2 No 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? Renal failure complation of cause of daath? Respiratory 1 Yas 2 No 1 ☐ Yas 2 No 25. Was cese rafarred to medical axaminar? 26. Placa of Death (Check only ona) Hospitel: 1 inpatiant 2 ER/Outpatlent 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yaa 2 No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? 5 Panding 1 MNatural 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be detarmined

Box 68760. P.O. Records, Division of Vitai

sician end burial-transit The law requires that the death certificate be assocuted physician of the burial been signed by the atter should be detached for it or Attanding Physician: funeral After death. after deatl Director: 24 hours a Hospital

Physician

/Medical

Examiner

Directo

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Pages 1 and 2 should be filled with threat of Health and Martal Hygen tant: If Item 27 is marked other the jury or other traumatic event, the

Separtment

Physician /Medical

Examiner

filled within

Baltimore, Maryland 21215-0020

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DHMH 16 Rev 6/95

State Registrar

600 North Wolfe 31. Data filed (Mark Pay Year) 2000

3 ☐ Suiclda

29a. Certifier

4 Homicida

(Check only one)

29b. Signature and titla of certifiar

30. Name and address of person who complated causa of death (Itam 23a) (Type, Print) Street 32. Flogistrar's Signatura

MD

Himore Ba

28a. Place of Injury - At homa, farm, street, factory, offica building, atc. (Specify)

RES-000

29d. Data signed (Month, Day, Year) March 14 2000

28t. Location (Street and Number of Rural Routa Number, City or Town, Stata)

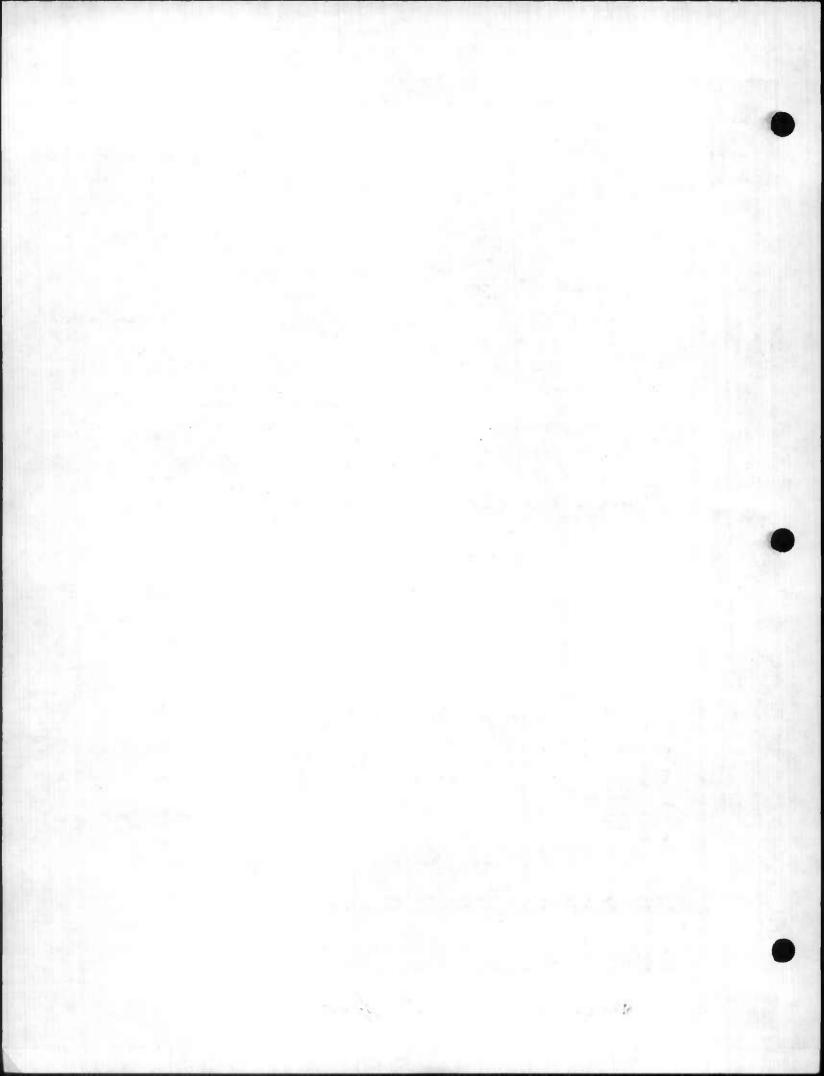
maryland Kaleb Yohay M.D.

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

| Certifying Physician: To the basis of examinetion end/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.

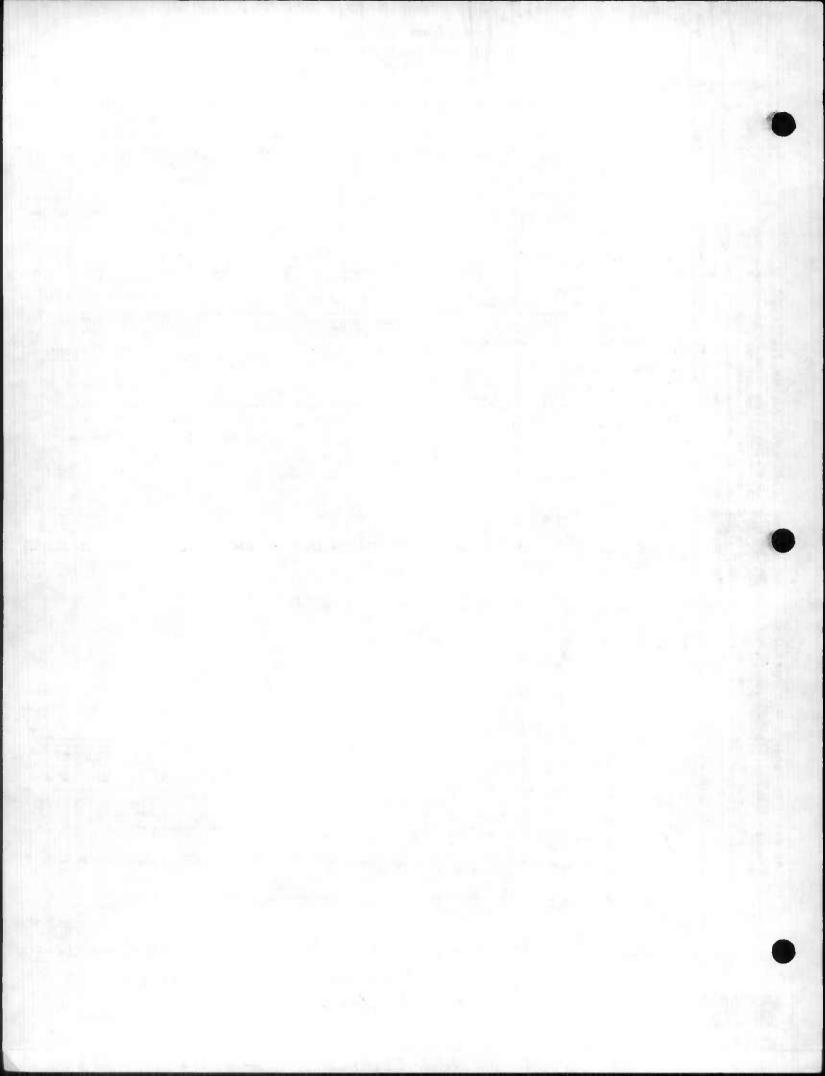
29c. License number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

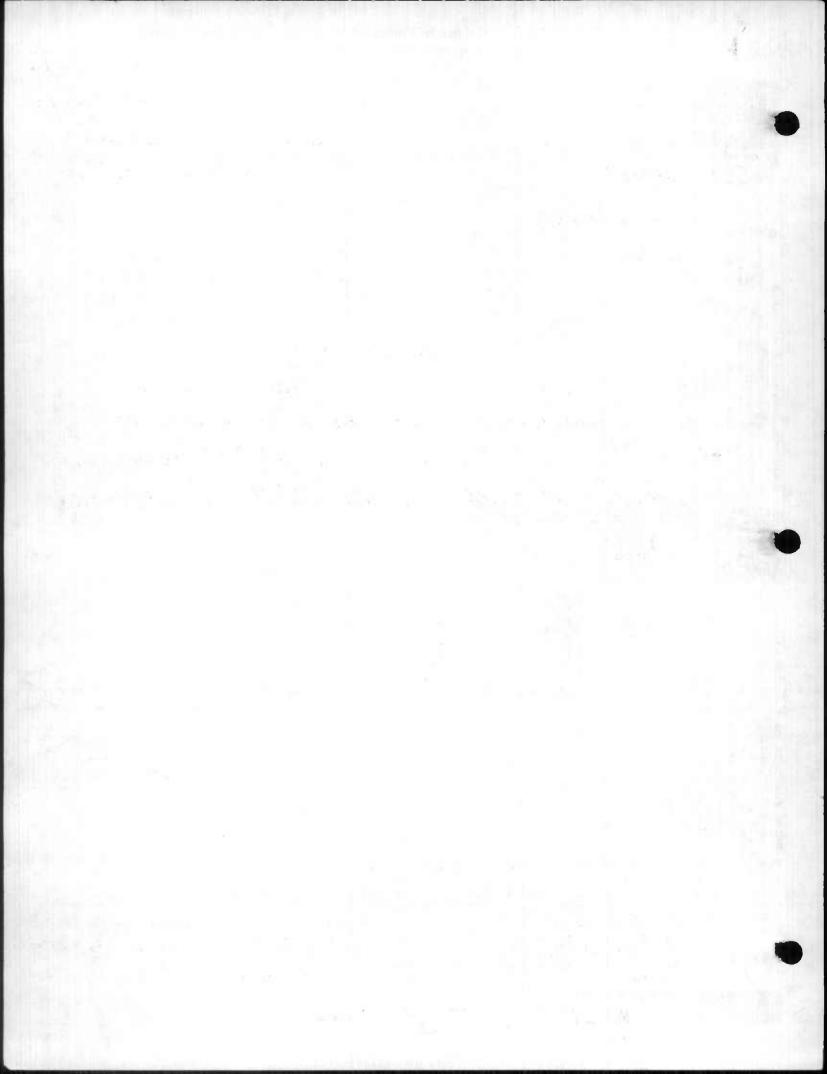
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Examiner	Saint Joseph		enter			Tows	on		Balti	imore	
Funeral Director	5. Social Security Number 6. Security Number 216-34-5185	Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hra. 8. Date of (Month) Montha Days Hours Min. Feb.					8. Date of Bird (Month, Da Feb. 2	of Birth h. Day, Year) 9. Birthplace (State or Fore Country) Maryland			
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urs after des aft, or thems Examiner m by Furne	11. Maritat Status 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Waa Decedent Ever in Armed Forcea? 1 Yes 2 X No it Yes, Give Year or Dates:	n U,S. 13	Nas Decede		ispanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)	14. Ra Bl	ace - American lack, White, etc. lify: W		
ed within 72 ho yglene. er than 'natur t, the Medical.	15. Decedent's Edit (Specify only highest grad		16a. Dec	edent's Usual	l Occup	ation Juring most of wor	king	16b. Kind of	Business/Indus	stry	
within the Man	Elementary/Secondary (0-12) 12th Grade	College (1-4or 5+)	(Give kind of work done during most of well the DO NOT use retired) Insurance Agent					iance C	ance Company		
tal Hygid d other	17. Father's Name (First, Middle, Last)						ne (First, Middle,	rst, Middle, Maiden Surname)			
Menta Menta Inhad Inhad	Roland Wilkinson	ı				Teresa	Lannon				
2 sho	19a. Informant'a Name/Relationship (T					and Number or Ru					
m 27	Mrs. Engrid C. Wi					th Court,		,			
mit. Pages 1 partment of He portent: If Item y Injury or oth	20a. Method of Disposition 1 TX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Parkwood Cemetery 3/18/00 Baltimore										
Depart Depart Import any in	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schumunek Funeral Home, Inc. 9705 Belair Rd., Baltimore, MD 2 23a. Part I. Enter the disease, or configurations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
Physician /Medical Examiner	tmmediate Cause (Finat disease or condition resulting in death)	METASTAT	O (or as a cons		MA	OF THE	PROSTA	TE	1	5 YEAR	
n certificate be executed unding physician end use as the burel-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	o (or as a cons						1 0 0		
death cer e attendin ed for use	Part II Other elemificant conditions co	ontributing to death but not resulting in the underlying cause given in Part t.					23b. Did tobacco use contribute to the cause of death?				
the section of	Tatil. Outsi alginican conducts co	ninbuling to death but not	resoluting at the	underlying ca	iuse giv	orin raitt.		Yes 2E No		bly 4 Unknow	
aw requir								an autopsy ormed?	availa	autopsy findings able prior to pletion of cause ath?	
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clan: ectori	25. Was case referred to medical examiner?	Hoenital:			Oth	26. Place of Dea	th (Check only o	one)			
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To the Hospital or Attending P within 24 hours after death. To the Funerel Director: Affer templetely filled in by the funer. Medical Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	y - At home, farm, street, factory, office			28f. Location (Street and Number or Rural Route Number City or Town, State)			Route Number,		
the Hospital or the Euneral Dir the Funeral Dir mplately filled in Medical Cert		rsician: To the best of my iner: On the basis of exam and manner stated.									
within 2 to the To the To the Med	29b. Signature and title of commer 29d. Date signed (Month, Da)										
0	Bealing	P. Wi	you!	7.0	164	92		man	h 13	,2000	
0	30. Name and address of person wife a BEATRIZ P. DIZC	IN M.D., 76	01 05		RIV	E, TOWS	ON, MA	RYLAN	D 2120	14	
State Registrar	31. Date filed (Manif. Pay 1 Yell) 200	32. Madelerary St	griature /	ppo	nk.	1					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			Ce	ertificate of	Death	R	eg. No.	0051			
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Medical	SARAH	ANN		WEHMEYER		MARCH	2, 2000	3:00 P.			
xaminer	4a. Facility Neme (If not institution, giv	ra street and number)			4b. City, Town, or Lo	ocation of Deeth	4c. County of De	eath			
	Genesis Elder Car	re			Severna H	ark	Anne Ar	undel			
neral	5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey,	Year) 9. B	lirthplace (State or For Country) 5 Texas			
ctor	459-10-3832 Usuel Residence of Decedent		84 Yrs.			Septemb	er 4, 191	5 Texas			
Hygiene. ther than "natural", or items 23a or 28a-f show but, the Medical Examiner must be notified at completed by Funeral Director	10e. Steta 10b. County		10c. City, Town or L	ocation				10d. inside City Lin			
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nd Mental Hygiene. merked other than "natural", or items 23s or 28s-f show imatic event, the Medical Examiner must be notified at I To Be Completed by Funeral Director	1 Never Merried 2 Married 3 分 Widowed 4 Divorced	1 Ves 2 No If Yes, Give Yaar or Detes:		1□Yes 2√√No	Specify:	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Specific	White			
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To	Paul Pov	well_			Erin		Andrew				
6	19e. Informent's Name/Reletionship (Type, Print)	19b. Meil	ling Address (Street	and Number or Rura	al Route Number	City or Town, State	, Zip Code)			
other traumatic	Janice Ann Harris	(Daughter)			Lane Pal	m Harbo	r F1 3468	3			
b .	20a. Method of Disposition 1 Burial XXCremetion 3	Removel from State	20b. Place of Disp cemetery, cre		ce)	Dete :	20c. Location - City of	or Town, State			
uny	4 ☐ Donetion 5 ☐ Other (Specify	y)	Chesapeak	ce Cremat:	ion Center	LLC	Stevens	ville, MD			
any injury o	21. Signature of Funerei Sarvice Licen	1500	2	z. Name end Addre	iss of Fecility			_			
Importan any injur once.	Singleton Funeral Home PA 1 Second Avenue S. W. Glen Burnie, MD 23a. Part1. Enter tha disease, or complications that cased the death. Do not antar the mode of dying, such as cardiac or respiratory arrast,										
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth **Physician** 2000 eer Mayoth 15. Dey 4:36 PM Elsie Yurkewich Webster /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore Co. Charlestown Health Center Catonsville 5. Sociel Security Number If Under 24 Hrs. If Under 1 Year 8. Dete of Birth Month, Dey, Year) June 08, 1917 9. Birthplace (State or Foreign Country) QUEENS, NEW YORK 7. Age (In yrs. last birthday) **Funeral** Devs 10 M 201 F Months Hours Director 212-05-1352 Usuel Residence of Decedent 10e. Stete 10c. City, Town or Location 10d. Inside City Limits Maryland Howard Co. Ellicott City Funeral Director 1 Yes 2 No 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21042-5310 4034 Dado Court United States of America 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Status Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Yes 2 No 1 Never Married 2 Married 1 Yes 2 No Specify: by Specify: White 3 Widowed 4 Divorced Yeer or Dales Be Completed 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondery (0-12) Supervisor C & P Telephone Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Alexander Yurkewich Anna Marin 10 19a. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs. Carole W. McShane(Daughter) 4034 Dado Court Ellicott City, Maryland 21042-5310 20b. Piece of Disposition (Neme of cemetery, cremetery or other plece) 20e. Method of Disposition 20c. Location - City or Town, Slete 1 XBuriai 2 ☐ Cremation 3 ☐ Removel from State Moreland Memorial Park 3/18/2000 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Punerel Service Licensee Jeffrey L. 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204-2515 234. Part Enfer tile disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, show, or heart failure. List only one cause on each line. Approximete ntervel Bety Onset end Deeth **Physician** immediate Cause (Final disease or condition resulting In death) /Medical NEUMONIA LWEEKS Examiner Due to (or es e consequence of): Examiner Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Couse (Disease or Injury that Initiated events resulting in deeth) Lesi Due to (or es e consequence of): Physician/Medical Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yea 2 ☐ No 3 ☐ Probably 4 ☐ Unknown EMENTIA Completed by 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? 1 ☐ Yes No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical exeminer? Be 26. Piece of Deeth (Check only one) Other: 4127Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. fnjury et Work? 28d. Describe how injury occurred Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office bullding, etc. (Specify) 4 Homicide Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, dete end piece, end due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end piece, end due to the cause(s) end menner stated. Medical 29e. Certifier (Check only one)

Box 68760. P.O. Division of Vital Records. Name Webster, Elsie To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral

the Maryland

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Manylan Department of Health and Mental thygiene. Important: If item 27 is marked other then "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Manyland Examiner man be nothined all

tha

signed by the attending of be datached for use as

been pega 2 s

this certificate

funeral director,

Baltimore, Maryland 21215-0020

State Registrar

29b. Signeture end title of certifier

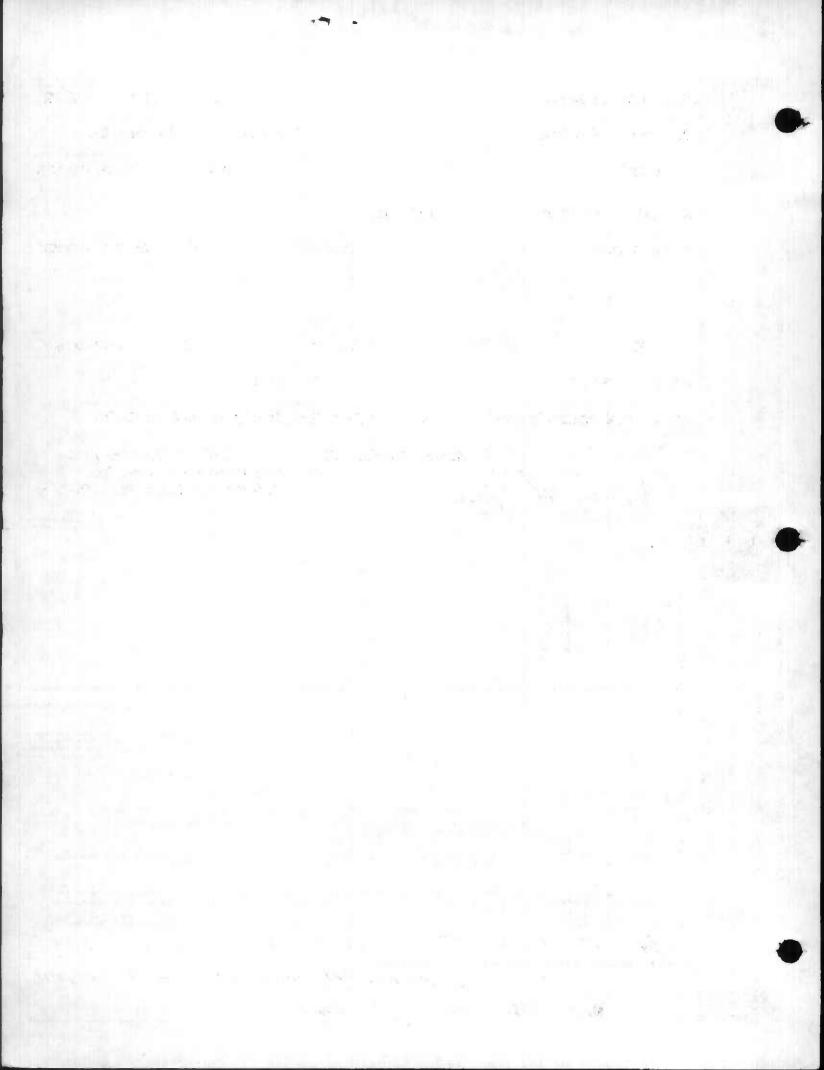
29c. License number

29d. Dete signed (Month, Dey, Year)

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

709 MAIDEN CHOICE LAVE BALTIMORE, MD YATTHEW R RETT. 31. Dete filed (Month, Dey, Year)

32. Registrar's Signeture 2000



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29a. Cer	tifier 15 Certifying Plack only 2 Medical Exa	nysician: To the best of miner: On the basis of and manner sta	of my knowled	dge, death occur	red at the	time, date and place					

Registrar

Joann Young

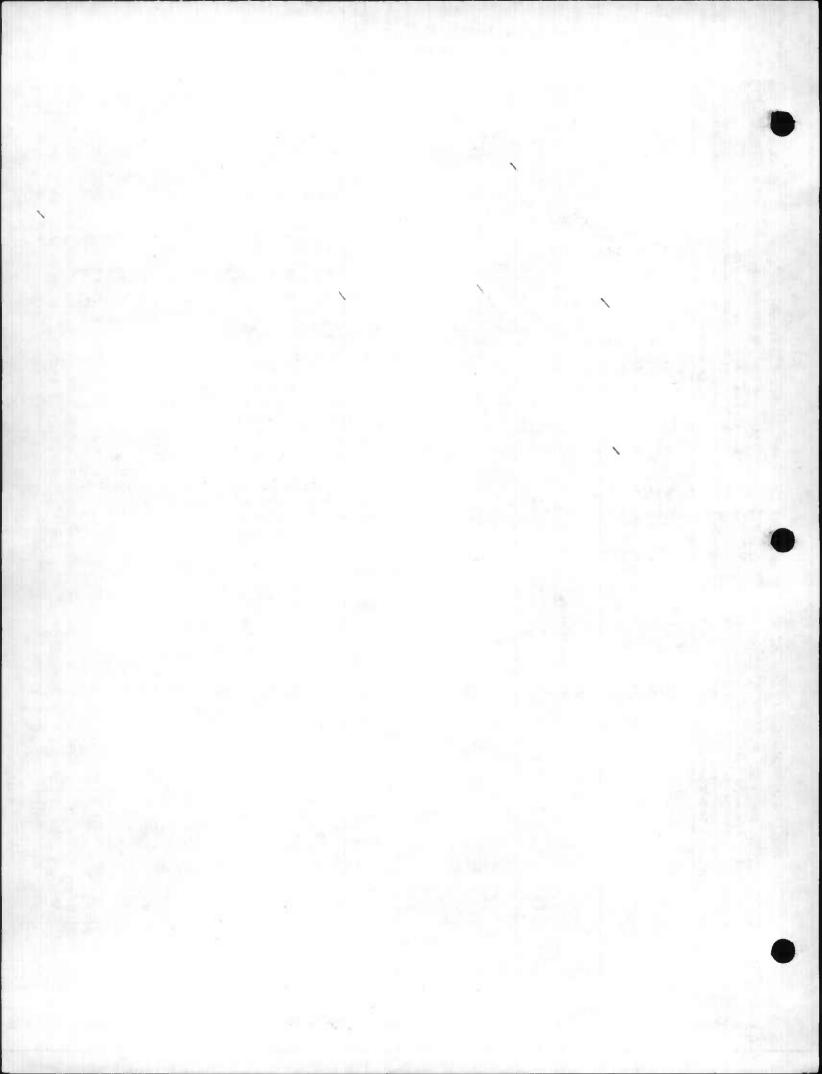
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD. TIMONIUM, MD

DR. TARIQ MAHMOOD

MAR 1

4372



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

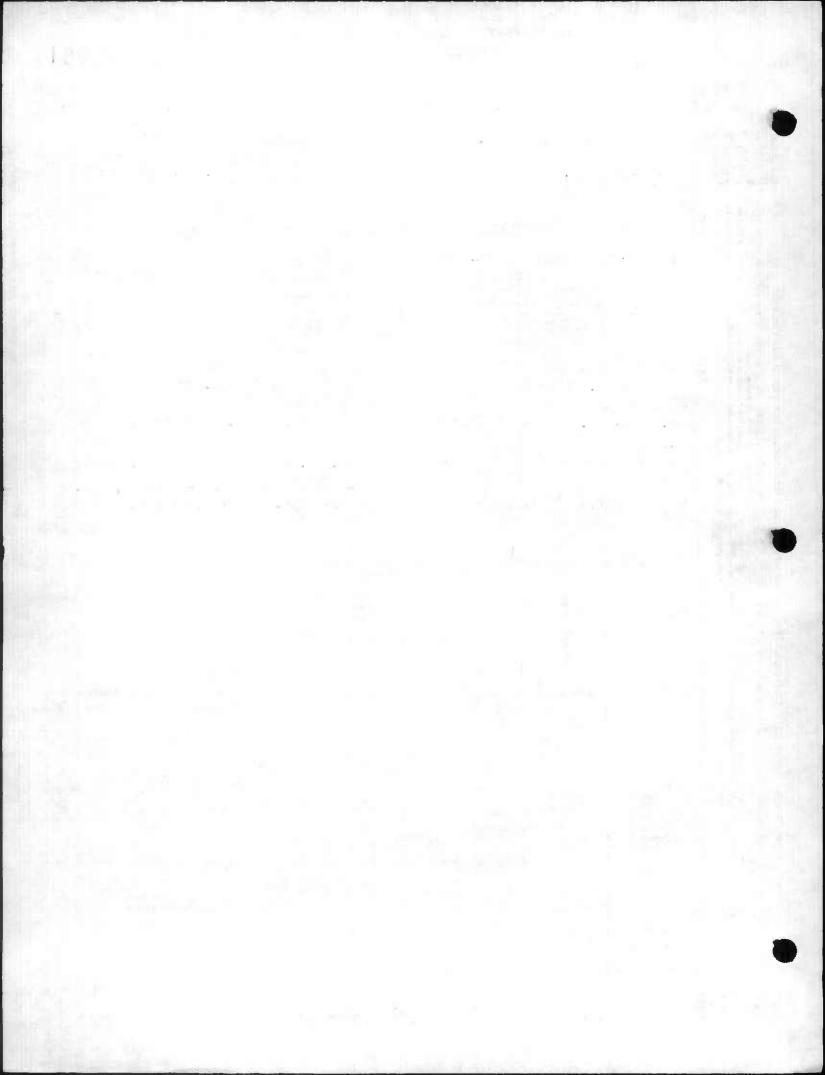
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or Arr or Arr or Direct in by	4 🗆 Homi	lcida determined	determined 28a. Place of Injury building, atc. (At home, farm, street, factory, office pecify)				28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)			
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State of Maryland / Department of Health and Mental Hygiene 0 08981

			Ce	rtificate d	of Death	R	eg. No.	00301		
Discolation	1. Decedent's Neme (First, Middle, Las	0				2. Date of Deal		3. Time of Death		
Physician Medical		Marlene	Ackwith		Month Dey Year March 15, 2000		10:00 P			
Examiner	4a Facility Name (If not institution, give	street and number)			4b. City, Town, or I	ocation of Death	4c. County of	of Death		
	3118 Wallford Dr:	ive Apt. B			Dundalk		Balt	imore		
Funeral Director	216-66-3331	7. Age (/	n yrs. last birthday, Yrs.	Months Da		8. Date of Birth (Month, Day, Sept.	Year) 10,1954	Birthplece (State or Foreign Country) Maryland		
P	Usual Residence of Decedent 10a. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limits		
death with the Maryland ms 23e or 28e-f show constitution to the control of the c		ltimore			Dunda	. 11-		1 ☐ Yes 2 ☐ No		
or 28s-f a	Maryland Ba. 10e. Street and Number		0g. Citizen of W	/hat Country?						
th with 23a or all Did	3118 Wallford Dr		United	States						
P. P. B.	11. Marital Status 1 Never Married 2 Merried 3 Widowed 4 Divorced	ive Apt. 12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 5 No II Yes, Give Year or Detes:	or in U,S. 13.	Was Decedent If Yes, specify C	of Hispanic Origin? (Scuban, Mexican, Puerto No Specify:	pecify Yes or No- o Rican, etc.)		- American Indien, k, White, etc. White		
Tz hours at natural; or distance by F	15. Decedent's Edu	ecation	16a. Dece	dent's Usual Oc	cupation		16b. Kind of Bus			
- 2	(Specify only highest grad Elementary/Secondary (0-12)	de completed) (Give kind of work life. DO NOT use			nne during most of wor tired)	king				
within or than	12 Years			1 Estate	e Broker	Real		1 Estate		
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and and m27	Mr. Daniel J. Ack				ord Drive	-	Dundalk			
S S S S S S S S S S S S S S S S S S S	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremetion 3 ☐ I		20b. Place of Dispo cemetery, cre	osition (Name or matory or other	place)	Date	20c. Location - 0	City or Town, State		
Pages ant: If It	4 □ Donation 5 □ Other (Specify,		Meadowri	dge Mem	. Pk. 3/20	/2000	Dorsey	, Maryland		
permit. Pages 1 and 2 should be filled within Department of Hashib and Mondal Hyghan. Important: If item 27 is marked other any injury or other traumatic avant, trait page. To Be Comp	21. Signature of Juneral Service Licens	Real	2	Duda-R	dress of Fecility uck Funera ise Ave.					
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Examiner	resulting in death)	Du	to (or as a conse	quence of):						
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- 6	examiner?	Hospitel:	2 ER/Outpatie	nt 3 DOA	Other: 4 Nursing H	ome 5 Reside	ence 6 Othe	or (Specify)		
nding Phys ath. r: After this a funeral di	27. Manner of Death Natural 5 Pending Accident Investigation	28a. Date of Injury (Month, Day Ye	M 28c.	28d. Describe how injury occurred						
To the Hospital or Attanding Phy within 24 hours attandant. To the Eureral Director: After thi completely illied in by the funeral	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
Ne Hospit n 24 hour Ne Funera pietely filli	29a. Certifier (Check only one) 2 Medical Emiry)	sician: To the best of m ner: On the basis of ex- steted	aminetion and/or in	h occurred at the vestigation, in n	e time, date and place ny opinion, death occu	, and due to the corred et the time, d	ause(s) and mar ate end place, e	nner as stated. and due to the ceuse(s)		
within To the comp	29b. Signature and Utleyof cogffice	1/	10	29c. Lic	ense number	2	9d. Date signed	(Month, Day, Year)		
d	1 / The	61	W	0	4547	5	3/16	0 (00		
(1)	30. Name and address of person who or	, Lane	_ 41	OS (Seltman	e Mi	212	257		
State Registrar	31. Date filed (Month, Day, Year) MAR 2 0 21	32. Registrer's	Signature	1. do	2. 1. 1	-				



Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 9:20pm Mar. 16, 2000 Ralph R. 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 1505 Ralworth Road Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 02-21-47 6 Sex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1X M 2□ F 218-48-2420 53 Usual Residence of Decedent 10a. Stete 10b. County 10c. City Town or Location 10d. Inside City Limits 1€ Yes 2 No NA Baltimore 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 1505 Ralworth Road 21218 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2\tilde{\text{U}} No ff Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Merital Stetus Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 10th Grade College (1-4or 5+) NA Operator Mass Transit Admin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Dunham Hilda Cannaday 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 19e. Informent's Neme/Reletionship (Type, Print) Ralph R. Brown, Jr. 1505 Ralworth Road Baltimore, Maryland 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State ₩ Buriel 2 Cremetion 3 Removel from Stete Woodlawn Cemetery 03-21-2000 Woodlawn, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility Baltimore, Maryland 21202 > & lady WM.C.March FH 1101 E. North Avenue w arres 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in deeth) Metastatic Cancer to LUNG & LIVER Due to (or as a consequence of): PRINMARY UNKNOWN 3-Months Due to (or as a consequence of): Due to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one)

Physician /Medical Examiner

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at or Attending Physician: The safter death.

N Director: After this certificated in by the funaral director, pages.

To the Hospital or within 24 hours after To the Funeral Dire completely filled in b

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Division of Vital

Physician/Medical Examiner

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Certification: To

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Physician

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Saltimore, Maryland 21215-0020

Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last

Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Hepatitis -B Infection

25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner of Death 1 Natural 2 Accident

5 Pending investigation

30. Name and address of person who completed cause of death (Ijem 23a) (Type, Print)

28a. Dete of Injury (Month, Day Year)

Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

281. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier

3 Suicide

4 | Homicide

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end menner stated. 29c. License number

29b. Signeture end title of certifier

6 Could not be determined

D-17992

29d. Date signed (Month, Day, Year) 3-17-00

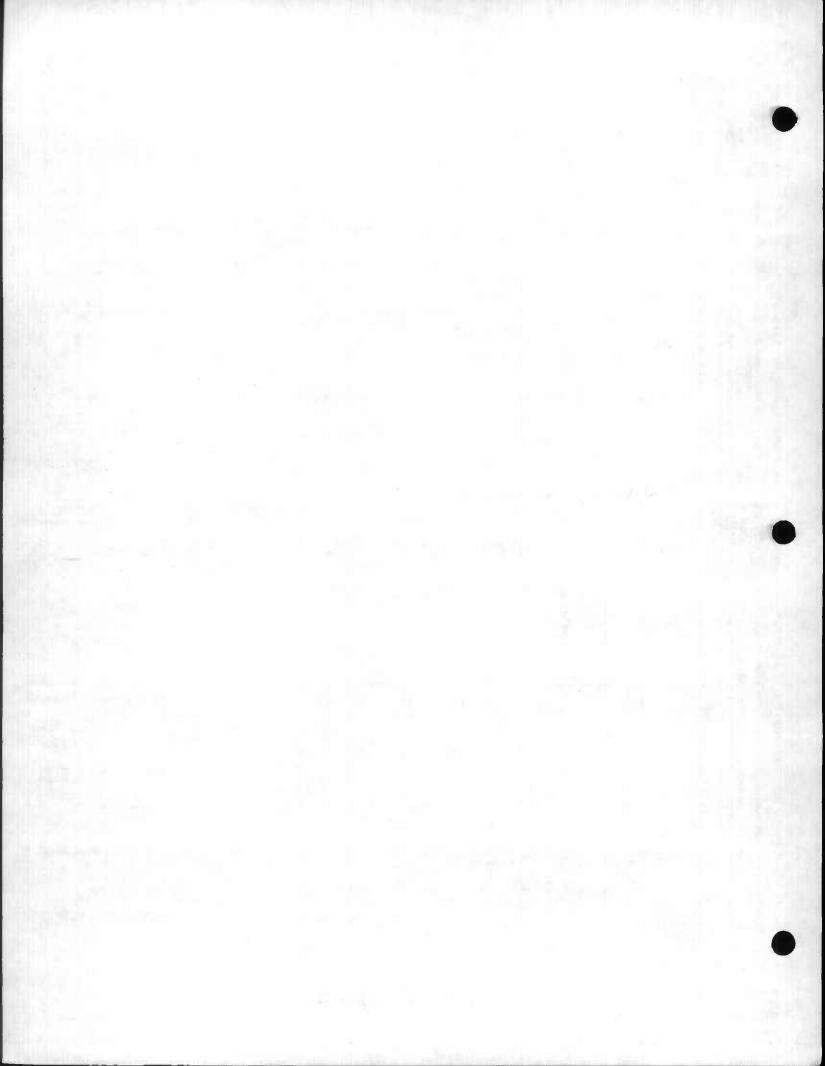
Goucher 13/2 31. Date filed (Month, Day, Year) MAR 2 0 2000

32. Régistrar's Signature

28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Towson md 21286

Registrar **DHMH 16 Rev 6/95**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 14 AW GRACE 19 6.40 2000 MARCH 4a Fscility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Northwest Hospital Center Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) Days 1 M 2 F Yrs 216-09-8545 92 Sept. 3, 1907 Maryland Usual Residence of Decedent 10n. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Baltimore Lochearn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6811 Campfield Road 21207 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indien, Bleck, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) 2+ Parke-Davis Secretary 17. Father's Name (First, Middle, Last) 16. Mother's Name (First, Middle, Meiden Sumeme) S. Eugene Bond Mary E. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Gladys Latch - Sister 6610 Eberle Drive; Apt. 203; Reisterstown, MD. 21215 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State t Burial 2 ☐ Cremation 3 ☐ Removel from State 4 Donation 5 Other (Specify) Druid Ridge Cemetery 3/21/2000 Pikesville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecilit Loring Byers Funeral Directors, Inc. H.FC. 0-8 M00869 8728 Liberty Road; Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) BILATERAT LDAYS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Wunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 NO No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Napatient 2 ER/Outpatient 3 DOA 1 Yes 2N No 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending investigation 15 Natural 1 Yes 2 No 2/ Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed use as the buriel-fran P.O. Box 68760, signed by I Records, peen certificate has Division of Vital Attending Physician: director, this of or Attentation of the state After

Physician/Medical Examiner à Completed Be Certification: To

n 24 hours after der ne Funeral Directo pietaly filled in by th

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To the Hospi within 24 hou To the Funer completely fil

State Registrar

Medical

DGINDER 31. Date filed (Mooth, Day, Year) MAR 2 0

4 ☐ Homicide

29a. Certifie

29b. Signature and title of certifier mehla mo went.

D. 41410

29c. License number

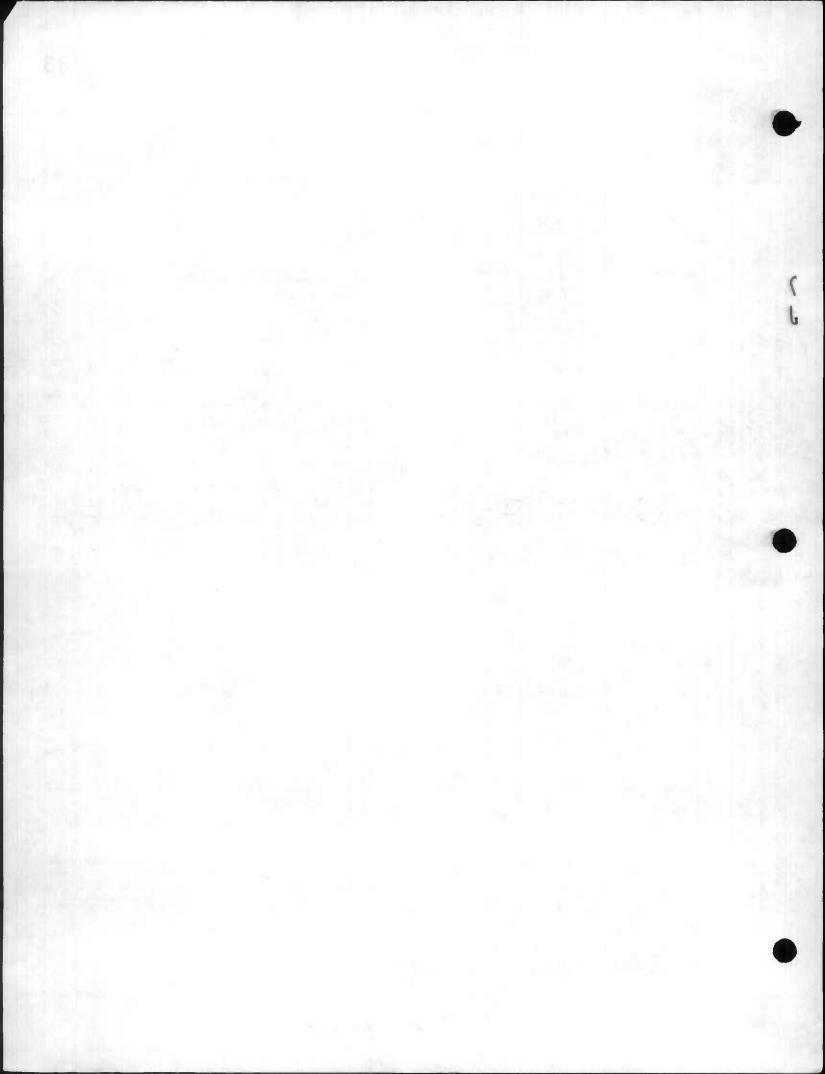
12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Dey, Year) 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HORTHWEST HOSPITAL CENTER BANDALLSTOWN mo

MEHTA 32. Registrar's Signature 2000

Maria



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 10e,19b per fh g783 5/30/00 yg Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth 50 PM Month **Physician** BUSCH MATILDA 13,2000 MARCH /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 1 ATI 920H PRINCE LAUREL AUREL REGIONAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) Months 1□ M 21 F Yrs. 276-28-5586 MAR. 12, 1928 Czechoslovakia Director Usuei Rasidence of Decedent 10a State 10b. County 10c, City, Town or Location 10d. Inside City Limits the Meryle 1 ☐ Yes 2 X No Director MD Prince George Laurel 10e. Street end Number 6918 MayFair Terrace 10f. Zip Coda 10g. Citizen of Whet Country? r than "natural", or items 23s or the Medical Examiner must be 6918 May Fare Drive 20707 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, 11. Maritai Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white 3 ☐ Widowed 4 ☑ Divorced þ Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collage (1-4or 5+) Hygiene. . Peges 1 end 2 should be filed w ment of Heelth end Mental Hygier tant: if item 27 is marked other th jury or other traumatic event, the 12 Homemaker Own Home 17. Fether's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Sumama) Suzanna Liptok Tobias Tomtchko 19b. Mailing Address (Strael and Number or Rurel Route Number, City or Town, Stata, Zip Code)
6918 May Fore Drive, Laurel, Md. 20707 19a. Informent's Name/Retationship (Type, Print) Henry Busch - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Dete 20c. Location - City or Town, State 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) 3/18/00 Meadowridge Memorial Park Elkridge, Md. 22. Name end Address of Fecility 21. Signeture of Fugeral Service Licensee, Gary L. Kaufman Funeral Home@ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md., earl failure. List only one cause on each line. elev 21075 Approximate Intervel Between Onset and Deeth **Physiclan** Immediate Cause (Finel disease or condition rasulting in daath) /Medical RESPIRATORY FAILURE DAYS Examiner Examiner DECUBITUS physician end the burief-transit be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Causa (Disaasa or injury that initiated evants resulting in deeth) Last Dua to (or es a consequence of): HEMIPARESIS Box 68760 Physician/Medical Dua to (or es e consequence of): 98 CEREBROVASCULAR ACCIDENT signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Wera autopsy findings eveilable prior to 24e. Was en autopsy performed? Completed completion of ceuse of death? SEIZURE 1 Yes 2 1 No 1 ☐ Yes 2 ☐ No or Attending Physician: effer death. Director: After this certifica 25. Was cese referred to medicel examiner?

1 Yes 2 10 26. Placa of Death (Check only ona) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) OL 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28e. Data of tnjury (Month, Dey Year) 28b. Tima of 28d. Dascribe how injury occurred Certification: 28c. tnjury at Work? 1 Winaturat 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Sulcide 6 Could not be datarmined Location (Street and Number or Rural Route Number, City or Town, Stete) 28a. Place of Injury - At home, farm, straet, factory, office building, etc. (Specify) 5 4 T Homicide Hospital 24 hours 1 P certifying Physician: To the best of my knowledga, deeth occurred et the time, dete end place, end due to tha ceusa(s) and mannar es atated. 29a, Certifier To the Hosp within 24 hor To the Fune completely fi edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and mennar stated. 29b. Signeture and title of certifier 29c. License number 29d. Date algned (Month, Dey, Year) MARCH 14,2000 D4-3575 30. Name and address of person who complated causa of death (itam 23a) (Type, Print) 735 o VAN DUSEN RD, # 130

State Registrar

31. Date filed (Month, Dey, Year)

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32. Registrar's Signature

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4-2-20-5 1 PROPERTY OF THE STREET STREET, STREET STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, ANNO SWEET FERRINGS STEELS A SOUN HISTANIAN S LARDAS GE LA WILLIAM 75×75 Edy 150 (4) (4) Sept of a contract of the party of the contract of

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Deta of Death March 15, 2000 11: 25Am 4c. County of Death Anne Bohnet 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore estown atonsville rare Center Hours Min. 8. Data of Birth (Month, Day, Year) May 31, 19 If Under 1 Year Months Days 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Washington DC Days 10 M 20 F 91 215-74-9124 Usual Residence of Decedent 10b. County 10s. State 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Catonsville 10e Street and Number 10f. Zio Code 10g. Citizen of What Country? 709 Maiden Choice Lane (South #112) 21228 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: White Specify: 3 ☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18, Mother's Neme (First, Middle, Maiden Sumeme) Charles Uppercue Miriam Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1601 Crestline Rd. Silver Spring, Md. 20904 Mr. Richard Bohnet/Son 20b. Place of Disposition (Name of carnetery, crematory or other place) 20n. Method of Disposition 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State bulaney Valley Mem. Grds. 3/20/00 Timonium, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Min Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, only one caused need fine. Approximate Interval Between Onset and Deeth Several Immediate Cause (Final disease or condition resulting in death) thero sc erotic cardiovascula years Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of deeth? 1 Ves 2 No 3 Probably 4 Punknown PNEWMONIA, UTINATY 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? infection Congestive hear 25. Was case referred to medical examiner 21010 1 Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1-No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 DNatural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide

Examiner physician and the burial-transit that the death certificate be axecuted Box 68760. P.O. signed by the a d be detached f Records, Division of Vital this After Attanding if or Attanding after death. I Director: Aft 24 hours a Funeral D To the Hosp within 24 ho To the Fune completely fi

Physician

/Medical

Examiner

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours effer of Depertment of Health end Mentel thyglene. Important: if item 27 is marked other than "natural", or her any injury or other treumade event, to be sent as I want and sent and the pages.

Physician

/Medical

Physician/Medical Examiner

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Certification:

29a. Certifier

(Check only one)

30. Name and address

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funeral

filled in

Baitimore, Maryland 21215-0020

Director

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Completed

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the Meryland

DHMH 16 Rev 6/95

State Registrar

ORIGINAL

Maiden

MT

32. Registrar's Signature

person who completed cause of death (Item 23a) (Type, Print)

one

1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

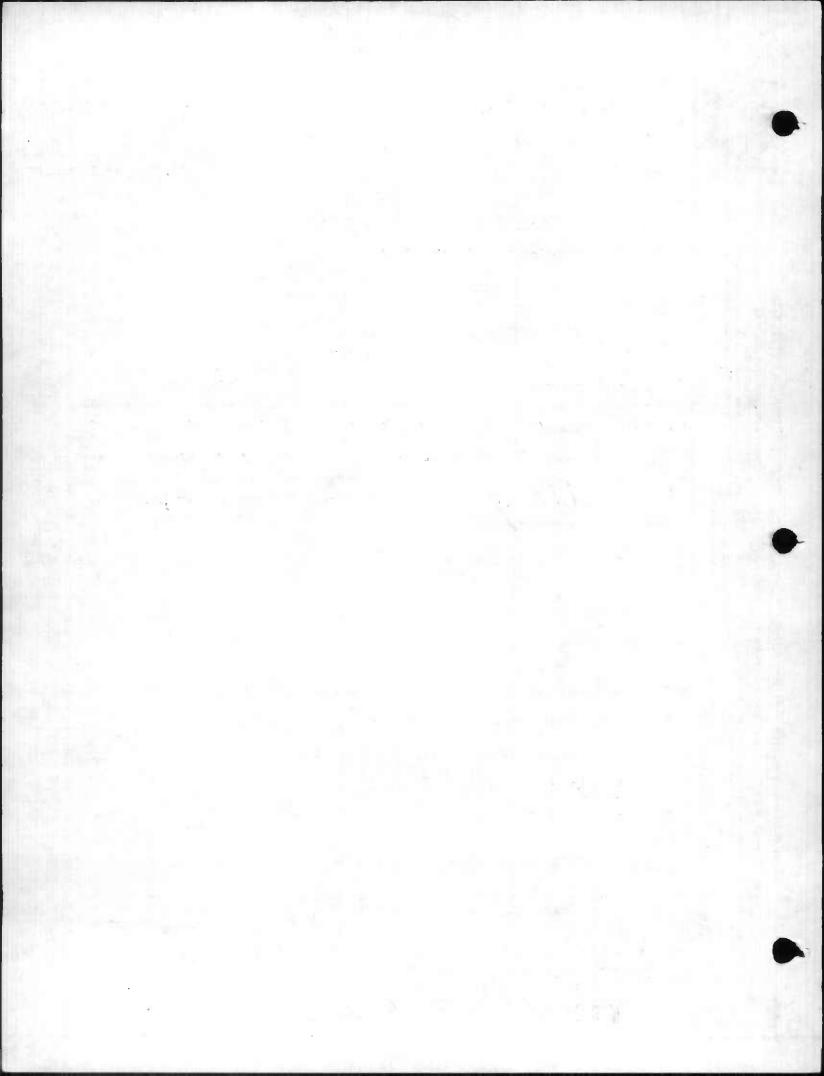
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. License number

parks

29d. Date signed (Month, Dey, Year)

Choice Lane, Catonsville, MD 21228



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dala of Death Month Day Year Margaret Jane Dunning 7:30 PM 17, MARCH 2000 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Baltimore TOWSOD Saint Joseph Medical Center 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, AUG. 23 5. Social Security Number Birthplace (State or Foreign Country) 1 M 2 F 214-01-1075 Maryland Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d Inside City Limits 1 ☐ Yas 2X No Baltimore Freeland 10s. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19821 Gore Mill Rd. 21053 USA Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 14. Race - Amarican Indian, Black, Whila, atc. 1 Nevar Married 2 Married 1 Yas 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Fathar's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) William Bowerman Elizabeth Kearnev 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. William Dunning/ Son 3908 Grave Run Rd. Millers, MD. 21102 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition Data 20c. Location - City or Town, Stala 1 Burial 2 Cremation 3 Removal from Stata 4 Donalion 5 Other (Specify) Hilltop Service Co. 3-20-00 Towson, MD. 22. Nama and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 21. Signature of Funeral Service Line 23a. Part1. Entar the disease or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. In only one cause on each line. Approximata Inlarval Batween Onset and Death fmmediata Causa (Final 3 HOURS ACUTE CONGESTIVE HEART FAILURE diseasa or condition resulting in death) Due to (or as a consequence of) 10 YRS. OBSTRUCTIVE CARDIOMEGALY Sequentially fist conditions, if any, leading to immediata cause. Enter Underlying Couse (Disease or injury that initialed events rasulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown STATUS POST LEFT NEPHRECTOMY 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? complation of causa of death? 1 Dyas 2 No 1 ∏ Yes 2 ∏ No

Physician /Medical Examiner

that the death certificate be axecu Box 68760.

P.O.

Records,

Division of Vitai

Physician

/Medical

Examiner

Funeral

Director

r than "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

Director

Funeral

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Completed

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the Maryland

death

be filed within 72 hours after de tai Hygiane. If other than "naturel", or hem

. Pages 1 and 2 should be flied w tment of Health and Mental Hygia lant: If them 27 is marked other ti Jury or other traumatic event, to

permit. Page Department of Important: If any injury or once.

altimore, Maryland 21215-0020

Examiner Physician/Medical þ Completed Be

physician and s the burlal-transit for use es signed by the page 2 ils certificata h director, page al or Attanding Physician: The safter death.

If Director: After this certificated in by the funeral director, pages. Certification: To

Medical To the Hosp within 24 ho To the Fune completely fi

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24 hours a Funeral D

State Registrar

31. Date filed /Mcs

25. Was casa refarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidance 6 Othar (Specify) Hospital: 1⊠ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Mannar of Deatl 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 2Bc. Injury at Work? 5 Pending invastigation 1 Natural 1 ☐ Yas 2 ☐ No 2 Accident 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 Could not be detarmined Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to tha causa(s) and mannar as stated. (Check only one)

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatura and titla of confi 29c. License number

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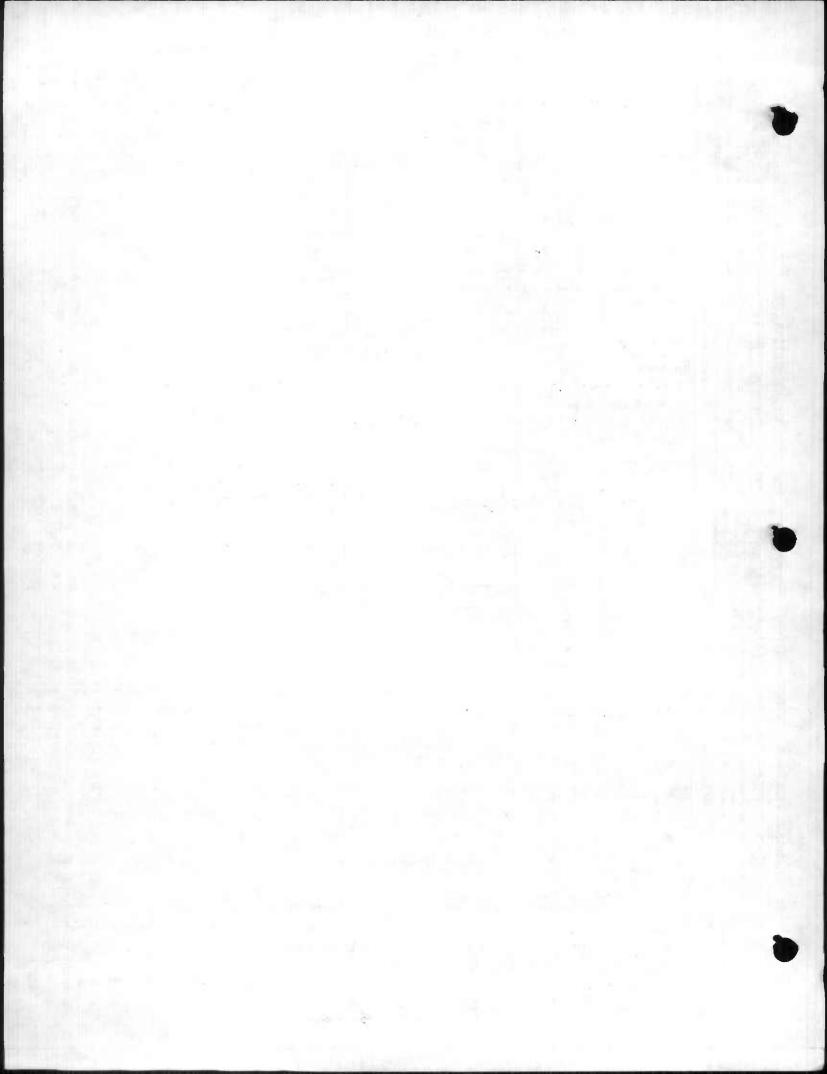
29d. Data signed (Month, Day, Year) 2000

son who completed cause of death (Item 23a) (Type, Print) 30. Name and add

M. D. , 7601 OSLER DRIVE, TOWSON, MARYLAND 21204 VARGA,

32. Registrar's Signatura MAR 200 2000

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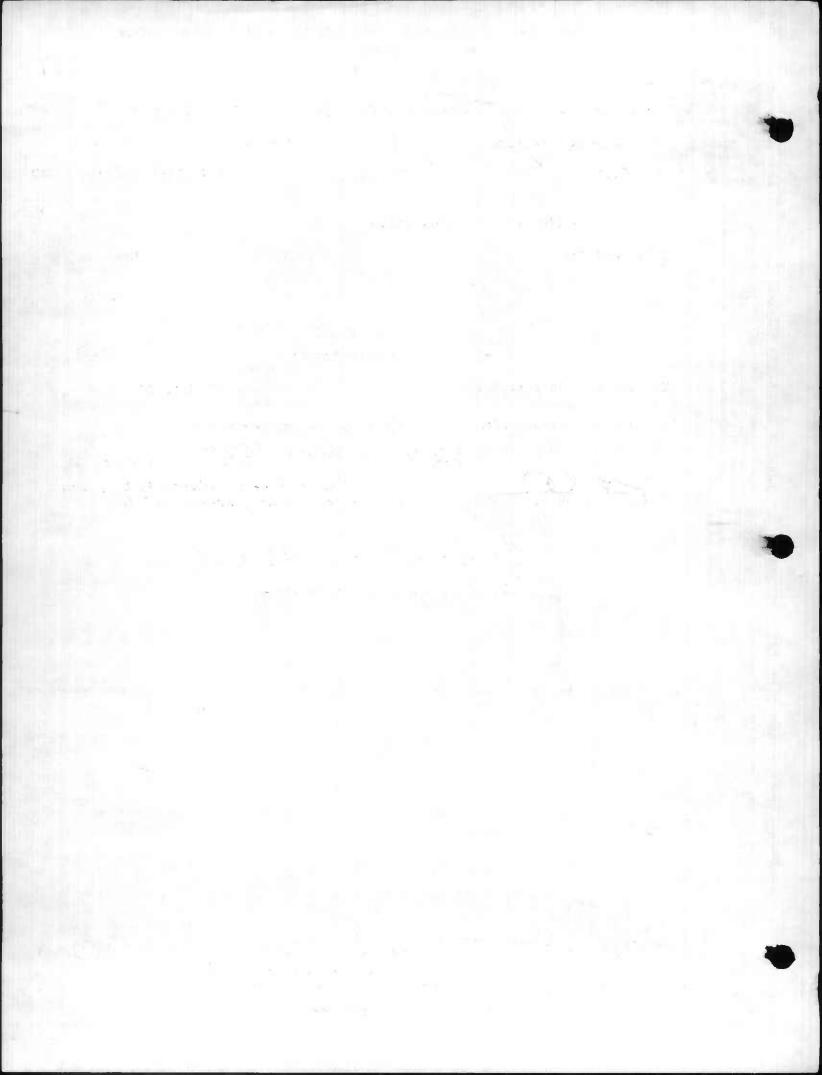
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** harles torresi /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Daath **Examiner** Towson
7. Age (In yrs. last birthday) If Under 1 Year if Under 24 Hrs. St. Joseph Hospital Baltimore 5. Social Security Number 6. Sex 1M M 2□ F 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min 50 Months Days Hours Yrs. July 9, 213-54-0884 1949 Director Baltimore, Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "naturel", or items 23a or 28a-f show treumstic event, the Medical Examiner must be notified at 1 Yes 2 No Director Baltimore Hunt_Valley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 Forwood Ct. 21030 Funeral USA death 12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☐ ANO If Yes, Give Yaar or Dates: 14. Race - American indian, Black, White, etc. 11 Maritai Status Was Decedant of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Pagas 1 and 2 should be filled within 72 hours after in ant of Haaith and Mental Hygiena. Int: If item 27 is marked other than "naturel", or ite 1 Navar Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0020 Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) Banking 4 Mortgage Banker 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Charles F. Ellinger, Sr. June R. Schlissler 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 10002 D. Old Providence Way

20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley Memorial March 22
Gardens Mary Denise Ellinger/Wife or other 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department of Important: If eny Injury or 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 21. Signature of Fur 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. Michael Flagle J. 10 W. Padonia Road Timonium, MD 21093 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrast, shock, or heart failure. List only one ceuse on each line. Approximeta Interval Between Onset and Death **Physician** /Medical immediate Cause (Finei disaase or condition resulting in death) **Examiner** Due to (or es e consequence of) Examiner requires that the death certificete be executed Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in deeth) Last Due to (or as a consequence of)? and buriel-trar physician Box 68760 Physician/Medical the Due to (or es a consequence of): 88 attanding 980 50 the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. signed by t detach 1 Yss 2 No 3 Probably 4 Unknown p 24b. Were eutopsy findings available prior to Completed 24e. Wes an eutopsy peeu completion of causa of deeth? hes page 2 1 Tas 2 No 1 ☐ Yes 2 ☐ No cartificate Hospital or Attending Physicien: funaral director, Be 25. Was cese referred to medical 26. Piece of Deeth (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After injury t @Naturai 5 Pending aftar daath. 1 Yes 2 No investigetion 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funerel Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dav. Year) 30: Name and addre of death (Item 23a) (Type, Pri

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State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Replacemen Certificate of Death . Decedent's Name (First, Middle, Lest) 2. Data of Daath Month Day **Physician** Year Ida Mae Virginia Engle February 01 2000 5:17 AM /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Western Maryland Center Hagerstown Washington 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Say 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (State or Foraign Country) **Funeral** Days Hours 1 M 2 KE Yrs. Director 69 233-02-0889 WV 10/07/1930 Usual Residence of Deceden the Marylend 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show benitfied MD Washington Director Hagerstown 1 TYas 2 No 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? ò 238 1500 Penna. Ave. 21740 Examiner name US Funerai death 12. Was Dacedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No if Yas, Give Year or Datas: or items 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 21215-0020 1 ☐ Yes 2 ☐ No Specify: by Specify: white 3 Widowed 4 Divorced 'natural', Completed the Medical 15. Decedent's Education (Specify only highest grada completed) 16a. Decadent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiena. Eiementary/Secondary (0-12) Coilege (1-4or 5+) Homemaker Home 7 is marked other traumatic event, Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumeme) Be Pages 1 and 2 should be nant of Haalth and Mental James Garland Engle ပ္ Sara Elizabeth Dillow Engle 19e. Informant's Name/Rejetionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) permit. Pages i and 2 s Depertment of Health ar Important: If Itam 27 is any Injury or other trau P.O. Box 234 Kearneysville, WV 25430 Nancy Engle - sister-in-law 20b. Place of Disposition (Neme of cemetery, cremetory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Murrill Hill Cemetery 2/4/00 | Harpers Ferry, WV 22. Name and Address of Facility
Jefferon Chapel Funeral Home 21. Signature of Funeral Sarvice Licensee P.O. Box 838 Charles Town, WV 25414 4 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata interval Between Onsat and Death **Physician** /Medicai Immediate Cause (Finel disaasa or condition resulting in death) a Anoxia Examiner Due to (or as a consequence of): Examiner Due to patient pulling out tracheal tube buriel-tran Sequentielly list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initieted events resulting In death) Last Due to (or as a consequence of): The law requires that the death certificate be execu Box 68760. physician Physician/Medical tha Due to (or as a consequence of) use as etten for P.O. Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco uss contribute to the causs of death? datached the 1 Yss 2 No 3 Probably 4 Unknown Records, by paga 2 should be 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? certificata hes 1 ☐ Yes 2 🕏 No 1 ☐ Yes 2 ☐ No of Vital or Attanding Physician: director, Be 25. Was case referred to medical 26. Piece of Death (Check only one) Hospitai: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 No Yes 2□ No this 28a. Date of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred When patient pulled out Certification: 28b. Time of 28c. Injury at Work? After Division 5 Pending investigation between Natural 1 Yes 2 No daeth. 02-01-2000 445:00 AM s after daeth the 2 XAccidant tracheal tube 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Burel Route Number, City or Town, State) 1500 Penn. Ave. filled in by 4 Homicide Western Maryland Center To the Hospital within 24 hours a To the Funeral C Hagerstown, MD 21740 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and dua to the cause(s) and manner es stated.

2 Madical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. Medicai (Check only one) 29b. Signature and title of certific 29c. License number 29d. Data signed (Month, Dev. Year) 00 D0011266 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Howard N. Weeks, MD 580 Northern Ave. Hagerstown, MD 21742

32. Registrar's Signature

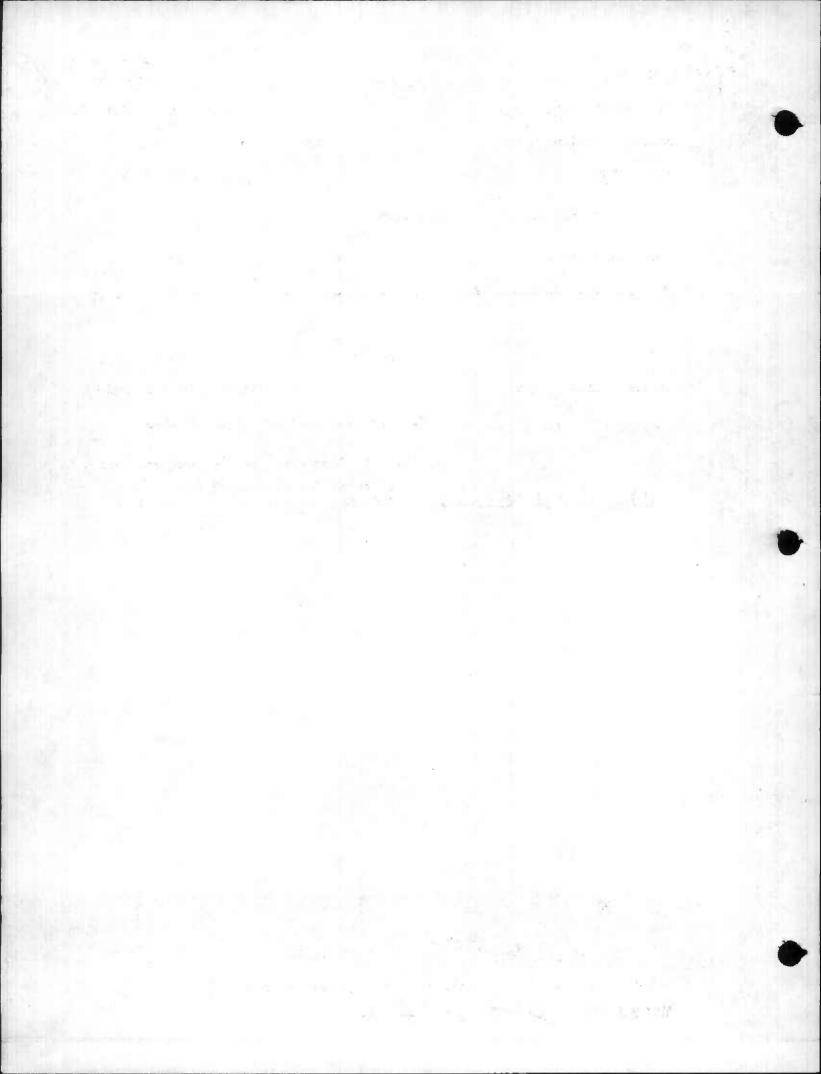
DHMH 16 Rev 6/95

State

Registrar

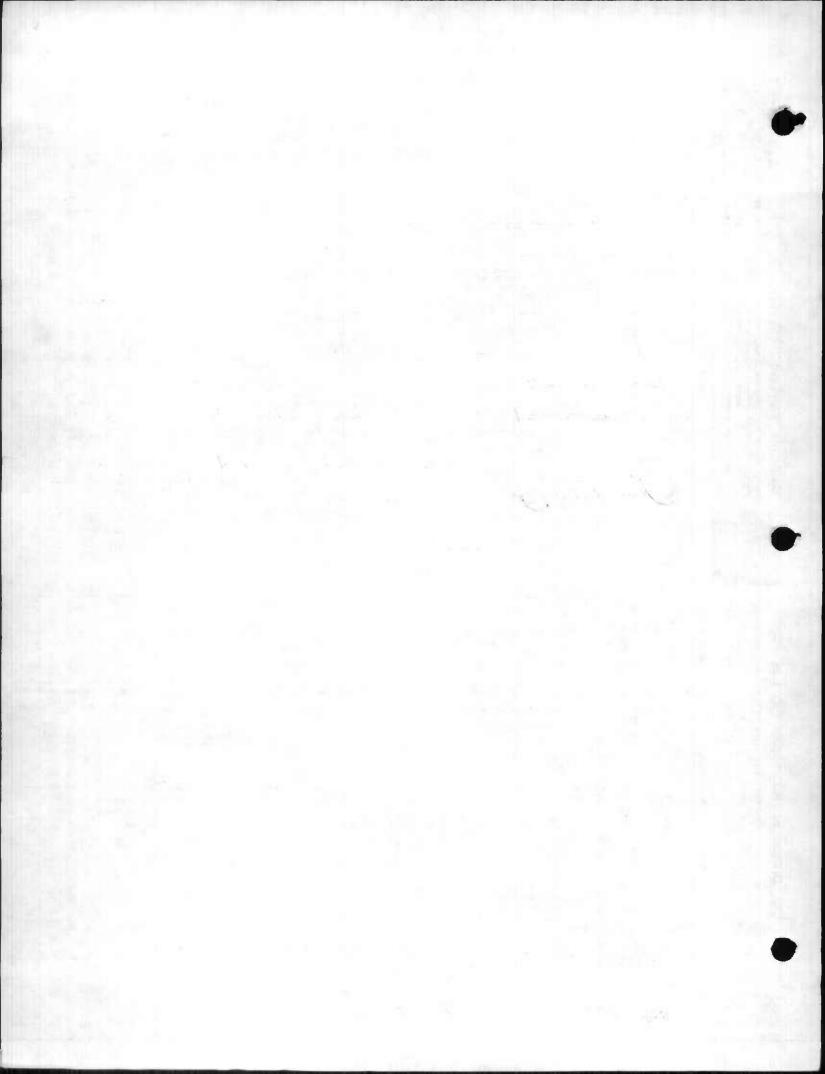
31. Date filed (Month, Dey, Yaar)

MAY 2 3 2000



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

	Decedent's Name (First, Middle, Last)			of Death Reg. No. 3. Time of Death						
Physician /Medical	John Robert Fisher				March	14,2000	2:00 A.M.			
Examiner	4a Fscility Name (If not institution, give street end number)	4	4b. City, Town, or Location of Death 4c. County of Death							
	Laurel Regional Hospital			Laurel			e George's			
Funeral Director	227-56-9899 XDM 2DF		If Under 1 Yeer Months Days	If Under 24 Hrs. Hours Min.	8. Dete of Birth (Month, Dey March	3,1947	9. Birthplace (State or Foreign Country) MCKENNY, VA			
anyland ahow	Usual Residence of Decedent 10a. Stete 10b. County 10c	c. City, Town or Loca	ition				10d. Inside City Limits			
the Man 28a-f at notified rector	MD Prince George's	Laure	e				1 XYes 2 No			
orrer death with the maryland friend 23e or 28e-f ahow river must be notified at Funeral Director	10e. Street and Number 13813 Briarwood Drive, #131	2	10f. Zip Code 207	08	1	U.S.A				
	11. Meritel Stetus 1 □ Never Merried 2 ☑ Merried 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever Armed Forces? 12. Was Decedent Ever Armed Forces?	4.5	as Decedent of H res, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black Specify.	a - American Indian, k, White, etc. : Black			
	15. Decedent's Education		nt's Usuel Occup	ation		16b. Kind of Bu				
than the complete	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 2 UCUTS 16a. Decedent's Usuel Occupation (Give kind of work done during most of willife. DO NOT use retired) Truck Driver			ing	Priv	ate				
marked other matic event, I	17. Father's Name (First, Middle, Last) John Robert Fisher		θ)							
9 4 9	19e. Intormant's Name/Reletionship (Type, Print) Susuan Eddies Fisher / Wife Susan Foole-Fisher	19b. Meiling 13813	Address (Street & Briarwo	and Number or Run Od Drive,	#1312	r, City or Town, Lawrel	Stete, Zip Code) , MD 20708			
ment of Health rismt: If hem 27 hisry or other to	1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal trom State	Ob. Place of Disposit cemetery, creme	tory or other plea		Date 3/18/00		City or Town, Stete			
Departs Imports any Inja	Dinuiddie Memorial Park 3/18/00 Dinuiddie, 22. Name and Address of Facility Latney's Funeral Hom CC0348 3831 Georgia Ave., NW, Wash., DC 20011									
hysician and wall-transit are the burial-transit are the burial-tran	disease or condition resulting in death) Due Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	n Cancer to (or as a conseque	ence ot):				Onset and Death 6 months			
ed by the attending physicis detached for use as the bu / Physician/Medical	that initiated events resulting in death) Last d.	to (or as e conseque	nce ot):							
the at hed for hed for	Part II. Other significant conditions contributing to death but no		erlying cause give							
ed by a detac	Metastasis to Liver and Lung				1 Yes 2 No 3 Probably 4 ⅓Unkn					
ate has been signed to page 2 should be det					24a. Was a perfor	24a. Was an autopsy performed? 24b. Were autopsy tindin available prior to completion of cause of deeth?				
page 2					1 🗆 Y	es 2 No	1 Yes 2 No			
certificate irector, pag	25. Was case referred to medical examiner?			26. Place of Deet	h (Check only or	10)				
r this certific val director,	1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient		3 DOA Oth	4 LI Nursing Ho	me 5 Resid	-				
octor: After by the funer Iffcation:	1 Natural 5 Pending (Month, Day Yea	ar) 28b. Time of Injury	28d. Describe h	ow injury occurr	eu					
rs after death. al Director: After ti led in by the funera Certification:	3 Suicide 6 Could not be determined 28e. Plece of Injury - building, etc. (S)	be d 28e. Plece of Injury - At home, farm, street, tactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number City or Town, State)								
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page Medical Certification: To Be Com	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one) 1 Medical Examiner: On the basis of examiner and manner stated.	y knowledge, death o mination and/or inves	ocurred at the tim stigetion, in my of	ne, date end place, pinion, death occurr	and due to the c red at the time, c	ause(s) and ma late end place, e	nner as stated. and due to the cause(s)			
within 24 hours. To the Funeral completely filled	29b. Signature and title of certitier	()	29c. Licenso	1.65-1.61			(Month, Day, Year)			
5	30. Name and address of person who completed cause of deeth	(Item 23a) (Type, Pri	D-254		07.07	3/14/20	00			
	John Margous, MD 15392 Bal 31. Date tiled (Month, Dey, Year) 32. Registrar's S		e., Lawr	el, MD 20	7707					
State Registrar	MAR 1 8 2000 Sand Sand Sand Sand Sand Sand Sand Sand	B. Lon	who!							



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hyg amend item 23a,27,28a,b,c,d,e,f per me G781 3/29/00 yg

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g. No.	00	00	2	J	1

	Physician
	/Medical
	Examiner
_	

288-7

ò Berns 23s

natural, or

a filed within 7 all Hygiens.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked oth any Injury or other traumatic event

200

72 hours after

Baitimore, Maryland 21215-0020

1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Anthony Stephen Guercio MARCH 13, 2000 0900 AM 4c. County of Deeth BALTIMORE 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death WAINWRIGHT CIRCLE OWINGS MILLS 7. Age (In yrs. last birthday) If Under 1 Year Months Days

Certificate of Death

5. Social Security Number **Funeral** 220-76-4624 Director

Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location

6. Şex † M 2□ F

If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) NOV . 29, 1960 9. Birthplece (State or Foreign Country) Mary Land

Directo

Funeral

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Completed

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Examine

Physician/Medical

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Completed

Be

To

Certification:

Medical completely

Maryland Baltimore

Baltimore

39

10d. Inside City Limits 1 ☐ Yes 2 No

10e. Street and Number

10f. Zip Code

10g. Citizen of What Country?

4422 Annapolis Road 11 Merital Status

1 Never Married 2 Merried 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ≥ 1 ☐ No If Yes, Give Year or Dates:

21227 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No Specify:

 Race - American Indian, Black, White, etc. Specify: White

United States

15. Decedent's Education (Specify only highest grade completed)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 12

College (1-4or 5+)

Barber

Cosmetology

17. Father's Neme (First, Middle, Last)

Peter Frank Guerico 19a. Informant's Name/Reletionship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Vera Guercio (Mother)

4422 Annapolis Road Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete

not enter the mode of dying, such as cardiac or respiratory arrest,

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify)

Metro Crematory, Inc.

13/8/00 Catonsville. MD

21. Signeture of Funeral Service Licenses

22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Lansdowne, MD 21227

18. Mother's Name (First, Middle, Maiden Surname)

Vera Commarata

Physician /Medical Examiner

sician and burial-transit

physi

USB

signed by the a d be detached f

page 2

this

Box 68760.

P.0.

Records.

of Vitai

Division

The law requires should should

Attending

death.

after deat Director:

Hospital or A
 24 hours after
 Funeral Dire
letaly filled in b

To the To the To the F

Immediate Cause (Finet disease or condition resulting in death)

METHADONE INIOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

23h. Did tohacco usa contributa to the causa of death? 1 Yas 2 No 3 Probably 4 Unknown

29d. Dete signed (Month, Day, Year) MARCH 14, 2000

24a. Wes an autopsy performed?

26. Place of Death (Check only one)

24b. Were eutopsy findings aveilable prior to completion of cause of death?

Yes 2 No

Yes 2 No

Approximete Interval Betwe Onsel end Death

25. Was case referred to medical examiner? Yes 2 No

27. Manner of Death

1 | Natural

2 ☐ Accident

3 Suicide

4 Homicide

5 Pending investigation

6 Could not be

Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Menth, Day Year) 28b. Time of found: 3/13/00 found 8:45

28c. Injury at Work? A

Other: 4 Nursing Home 5 Residence &XOther (Specify) SCENE 28d. Describe how injury occurred UNKNOWN

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify). found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State) /,711 1.12 Owings Mill, MI Wainwright Cir.,

29a. Certifier (Check only one) 1 Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

**Medical Examination Course Date: of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the object of the course mination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

> 29c. License number O.C.M.E.

1 Yes 2 No

29b. Signature end title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed (Month, Day, Year)

. . .

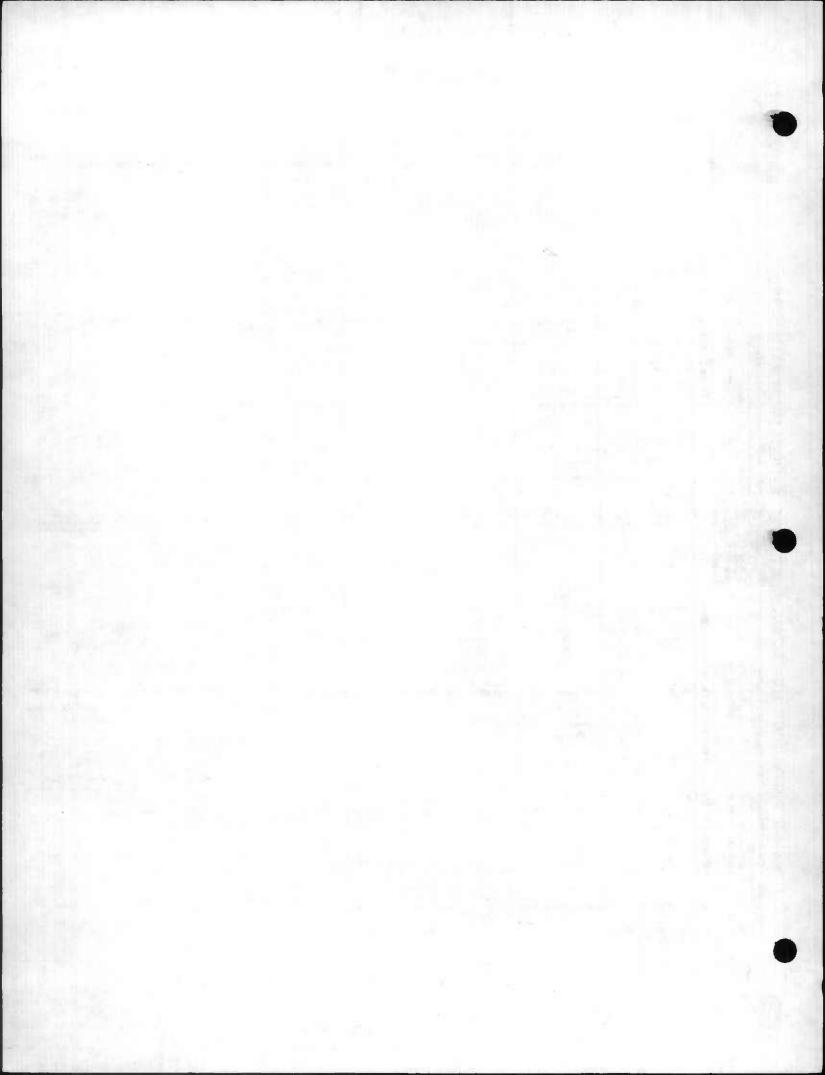
MAR 20 2000

avles

32. Registrar's Signature

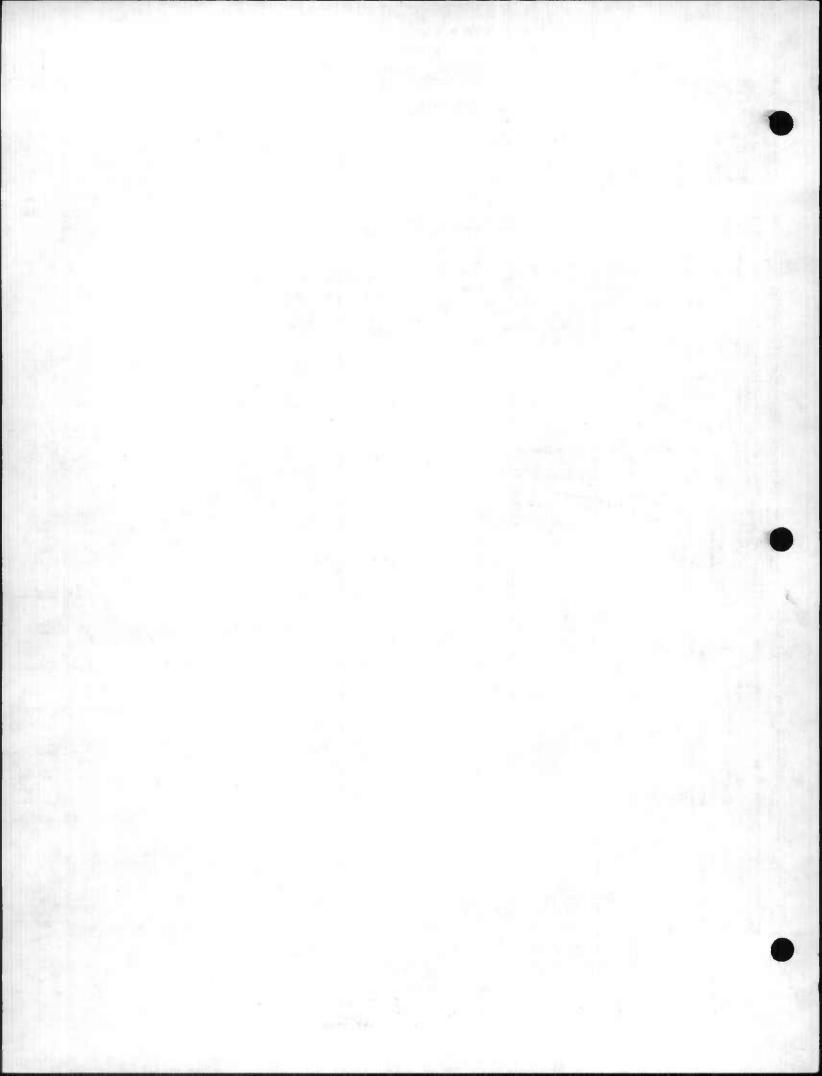
DHMH 16 Rev 6/95

ORIGINAL



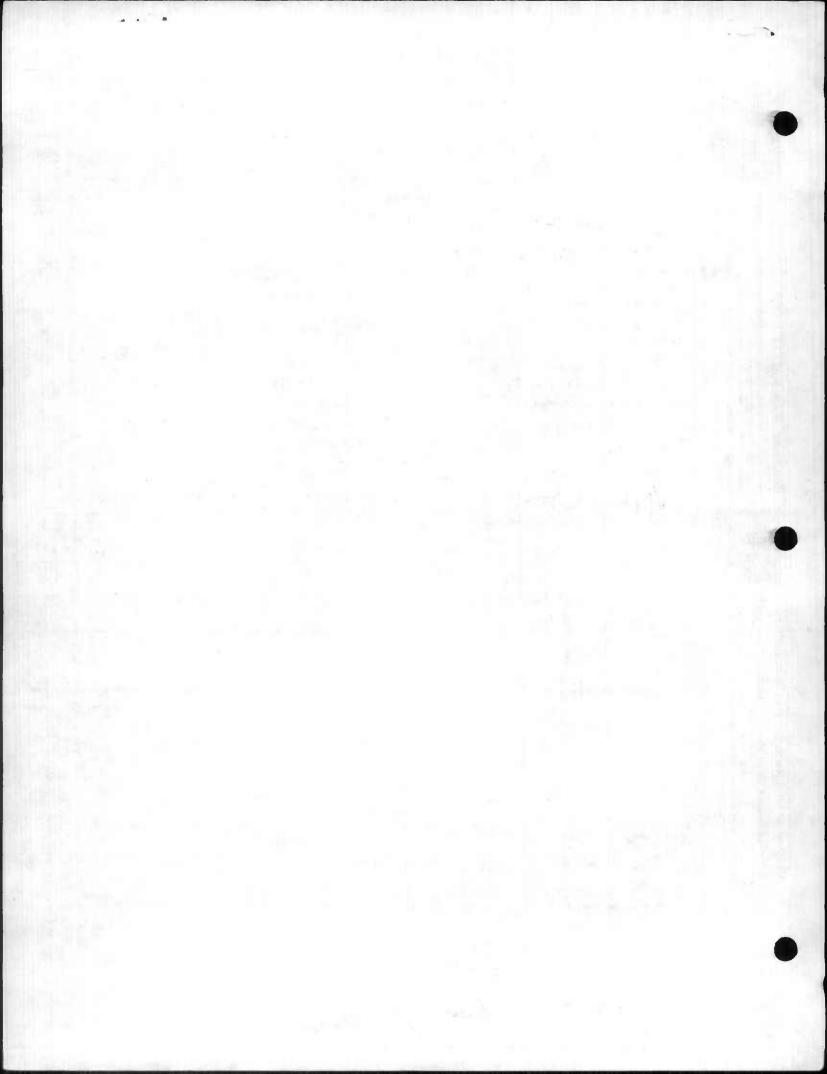
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Merch 03 **Physician** Gapinski 1915 Mary 00 /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Baltimore City Hopkins Bayview Med Center Baltimore H Under 1 Year If Under 24 Hrs. 8. Data of Birth 9. Birthplace (State or Foreign Months Days Hours Min. July 21, 1923 Maryland 5. Social Sacurity Number 6. Sax 7. Age (In yrs. last birthday) **Funeral** 1□M 2\ F 76 217 12 6333 Director Usual Rasidance of Decedant 10a State 10b Counts 10c. City, Town or Location 10d. Inside City Limits 1 Yes ZONO Dundalk Maryland Baltimore 28a-f Directo 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 21222 3122 Cornwall Road 238 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U,S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 Yas 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yas 2 XNo Specify: Specify: þ White 3 Widowed 4 Divorced Yaar or Datas: Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Aero Space Machine Operator 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Pages 1 and 2 should be fill ment of Health and Mental Haust, if Item 27 is marked oth lary or other traumatic event Elizabeth Macessy John Barrett 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 3122 Cornwall Road, Baltimore, Maryland 21222 James Gapinski (son) 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 12 Burial 2 Cramation 3 Ramoval from Stata Department of Important: If any injury or 3/21/2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart of Jesus 22. Nama and Addrass of Facility
Bruzdzinski Funeral Home, P.A. 21-Signature of Peneral Service License 1407 Old Eastern Avenue, Essex, Maryland 21221 23a Part of the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, sock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediata Causa (Final Dastrountestinal Bleeding disaase or condition resulting in daath) Examiner Dua to (or as a consequence of): Examiner Renal Failur Sequentially list conditions, if any, laading to immediata cause. Enter Underlying Cause (Disaase or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) Box 68760. Due to (or es e consequence of) Physician/Medical the Obstructive Pulm disease signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 0.0 1 Yes 2 No 3 Probably Unknown Division of Vital Records. Be Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 2 No 1 Yas 2 No or Attending Physician: 25. Was casa rafarred to medical examinar? 26. Place of Death (Check only one) 1 Yas 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Medical Certification: To 1 Denpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28h Time of 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Panding invastigation death. 1 Yes 2 No Alter death 3 Suicida 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, atreet, factory, office building, atc. (Specify) filled in by 4 Homicide 24 hours a Hospital 29a. Cartifier 🔀 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Within 2 To the 29b. Signature and title of certifiar 29c. License number 29d. Data signed (Month, Day, Year) E. Martin D.O. Resident 30. Nama and addrass of person who completed causa of death (Item 23a) (Type, Print) Hopkins BAYVIEW MED CTA. 201 martin Johns SALTO. 31. Date filed (Month, Day, Year) MAR 20 State 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

		State of Maryland	d / Department of Certificate of			ene O (08992			
Physician /Medical	1. Decedent's Neme (First, Middle, Last) Walter		rch 16, 2000 1:25 PM							
Examiner	4a Facility Name (M not institution, give s Charlestown Care			4b. City, Town, or Lo Catonsvil		4c. County of De Baltimo				
Funeral Director	3/7-07-3040	7. Age (In yrs. la M 2 F 95	Yrs. If Under 1 Year Months Days		8. Dete of Birth (Month, Day,) July 11,	^(ear) 1904	irthplace (State or Foreign Country) Maryland			
deeth with the Maryland ms 23a or 28a-f show creat be notified at	Usual Residence of Decedent 10a. State 10b. County MD Baltimore 10e. Street and Number	e Ca	atonsville		10(). Citizen of What (10d. Inside City Limits 1 ☐ Yes 2 🕅 No Country?			
urs after ar, or its by Fui	1 Never Married 2 Merried	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 10 No If Yes, Give Year or Detes:	21228 3. Was Decedent of If Yes, specify Cult	Hispanic Origin? (Spe ban, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	United States ify Yes or No- lican, etc.) 14. Race - American Indien, Bleck, White, etc. Specify: White				
d within 72 glene. Ir than "nell in the decision of the decisi	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12		16a. Decedent's Usual Occ. (Give kind of work done life. DO NOT use refin	e during most of working)	ng	l ub				
Mentel Mentel	John T. Gosne:			18. Mother's Name		Westawa	•			
Pages 1 and 2 shr ent of Health end aft. If tem 27 is m by or other treum	19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stell 12 Maryland Ave. Towson, MD 2' 20a. Method of Disposition 1 Burial 2 XX remation 3 Removel from State 4 Donation 5 Other (Specify) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stell 12 Maryland Ave. Towson, MD 2' 20b. Place of Disposition (Name of cemetery, crematory or other place) Hilltop Svc. Corp. 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stell 10c. Place of Disposition (Name of cemetery, crematory or other place) 10c. Place of Disposition (Name of cemetery, crematory or other place) 10c. Place of Disposition (Name of cemetery, crematory or other place) 10c. Place of Disposition (Name of cemetery, crematory or other place) 10c. Place of Disposition (Name of cemetery, crematory or other place)									
Departme Departme Importan any Injur	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Learns			ress of Facility Ruc	k Towson	Towson, Funeral ryland 2	Home, Inc.			
Physician /Medical Examiner	23a. Part1. Effect the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequence of):									
desth certificate be axecuted to a transit of or use as the burist-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):									
et the deeth certific d by the attending petached for use as	Part II. Other significant conditions cont	ributing to death but not resul	ting in the underlying cause g	iven in Pert I.	23b. Did tob	۸	rie to the cause of death? Probably 4 Unknown			
hes been signed by 2 should be d					24a. Wes an performe	autopsy 24l	b. Were autopsy findings available prior to completion of cause of death?			
Ing Physicians After this cardific	25. Was case referred to medical examiner? 1 Yes 25. No Ho 27. Manner of Death Natural 5 Pending investigation 3 Suicide 6 Could not be		28b. Time of Injury 28c. Injury	28c. Injury at Work? 28d. Describe how Injury occurred						
To the Heaptal or Attand within 24 hours after down to the Funeral Director; completely filled in by the Medical Certificat	4 Homicide determined 29a. Certifier 1 Certifying Physi	28e. Place of Injury - At hon building, etc. (Specify)	ime, date end place, a	City or Town, and due to the cau	Stete)	Rural Route Number, as stated.				
To the Hospital or within 24 hours all or To the Funeral D completely filled I Medical Ce	29b. Signature and title of perfilier	and manner stated.	on end/or investigation, in my 29c. Licer	opinion, death occurre	290	3. Date signed (Mo	onth, Day, Year)			
\bigcirc	30. Name and address of person who con Awar La Tr.	5 711 N	neidn che	io lau	c Cal	narch 15	ve			
State Registrar	31. Date filed (Month, Day, Year) MAR 2 0 20	32. Registrar's Signatu	B 10-			•	-			



Funeral Director

"natural", or flams 23a or 28a-f show idical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Mealth and Mental Hygiens.

important: if them 27 is marked other than any injury or other trauments

Physician /Medical Examiner

Baltimore, Maryland 21215-0020

Please Type or Print In Black Indelibie Ink. Assure Ail Copies Are Legible.

	S	tate of M	faryland		partment ertificate			and M	Mental H		ene (0	089	93
1. Decedent's Name (Firs	t, Middle, Last)								2. Dete of	Dooth			3. Tima of	Death
JAMES N	ITCHAFI	GEAR	٧						Month MARCH	1 14	Dey 200	Year	1.6:3	5 PM
4a Facility Name (If not in				-		1	4b. City. To	wn. or L	ocation of De	ath	4c. County	of Death		5 222
1.1 WEST 20	_		,					TIMO				/ A		
5 Social Security Number	Social Security Number 6. Sex. 7. Age (In yrs. last birthday) If Under 1 Year If Under								8 Dete of	Birth		,	placa (Stete d	or Foreign
218-03-8714 Usual Residence of Dece	218-03-8714 YCAM 2□F 8					Deys	Hours	Min.	8. Dete of (Month, March	Dev. Y	1911	MAR	YLAND	, roloigi
	County		10c. City	, Town or	Location								10d. Inside C	ity Limits
MD.	N/A		BA	LTIM	ORE								1 💢 Yes	2 No
10e. Street and Number	,,,				10f. Zip C	ode				100	. Citizen of \	Whet Cou	intry?	
11 WEST 20	th STREE	T				212					U.S.	Α.		
1) Never Merried 2	11. Merital Status 1\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\)\(\						tispanic Ori an, Mexican Specify:		ecify Yes or Rican, etc.)	No-		ck, White		
(Specify onl	ecedent's Education y highest grade co	mpleted)		16a. De (Gi	cedent's Usual (ive kind of work a. DO NOT use	Occup done retire	pation during mos d)	t of worl	ing	16	b. Kind of B			
Elementary/Secondary	(0-12)	College (1-4o	5+)		SEAMAN					SHIPPING				
17. Father's Name (First,	Middle, Last)						18. Mothe	r's Nam	e (First, Mide	dle, Ma	iden Sumen	ne)		
WILLIAM GEA	RY						Δη	A KE	VFS					
19a. Informant's Neme/R		Print)		19b. Me	eiling Address (Street				nber, C	City or Town,	Stete, Z	ip Code)	
ANDREW DOWE	n	AL DIR	20b. Pl	ace of Dis	1 EASTE	of		JE, B	ALTIMO Dete		MARYL/ c. Location		21231 own, Stete	
1/□XBurial 2 □ Cred 4 □ Donation 5 □ C		ovel from State	8	RKWOO				/16/	nn	R	ΔΙΤΙΜΟ	DRE N	MARYLAN	ID
21. Signature of Funeral	Acces.	12	A	5	22. Name and LILLY & 1901 EA	Addre Z	EILER ERN A	INC /ENU	. FUNE	RAL	HOME RE.MAR			
23a. Pert1. Enter the dis- shock, or heart feilu	ease, or complications. List only one control	ons that cause ause on eech	line.		^		ng, such as	cardiac	or respiretor	y erres	t,	1	Approximat Intervel Bet Onset and	tween
Immediate Cause (Final disease or condition resulting in death)	a	4			tvyntn sequence of):	11A				_		1		
		Anle	resclere	TIC (Cardiova	scu	LAR I	Dise	Fe.			3		
Sequentially list condition if any, leading to immedia cause. Enter Underlying	s, ite	TINE			sequence of):						L. W.	1		
Cause (Disease or injury that initieted events resulting in death) Last	c		Due to (or	es e cons	sequence of):							1	7	
Death Other 1 17	d			hat					1					
Pert II. Other significant of	conditions contrib	лing to death	out not resu	ining in the	e underlying cau	ise gi	ven in Part			□ Yaa	/		to the causa obably 4	
	1000		911		176					es en a	autopsy id?	a	Vere autopsy vailable prior ompletion of a f death?	10
									1	☐ Yes	2 No	1	□ Yes 2 X	No

ate has been signed by the attending physician and page 2 should be deteched for use as the burial-transit The law requires that the death certificate be axecuted Division of Vital Records, P.O. Box 68760. certificate has To the Hospital or Attanding Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, I

Medical Certification: To Be Completed by Physician/Medical Examin

25. Was case referred to medical examiner?
1 Yes 2 No 27. Manner of Death 1 Natural

5 Pending investigation 2 Accident 3 ☐ Suicide 4 ☐ Homicide

29e. Certifier

6 Could not be determined

28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA

28c. Injury at Work? 1 Yes 2 No

281. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Deeth (Check only one)

t Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, end due to the ceuse(s) end manner as stated.

2XI Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and plece, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and title of eqrtifie

OCME

29c. License number

29d. Date signed (Month, Dey, Year) MARCH 15, 2000

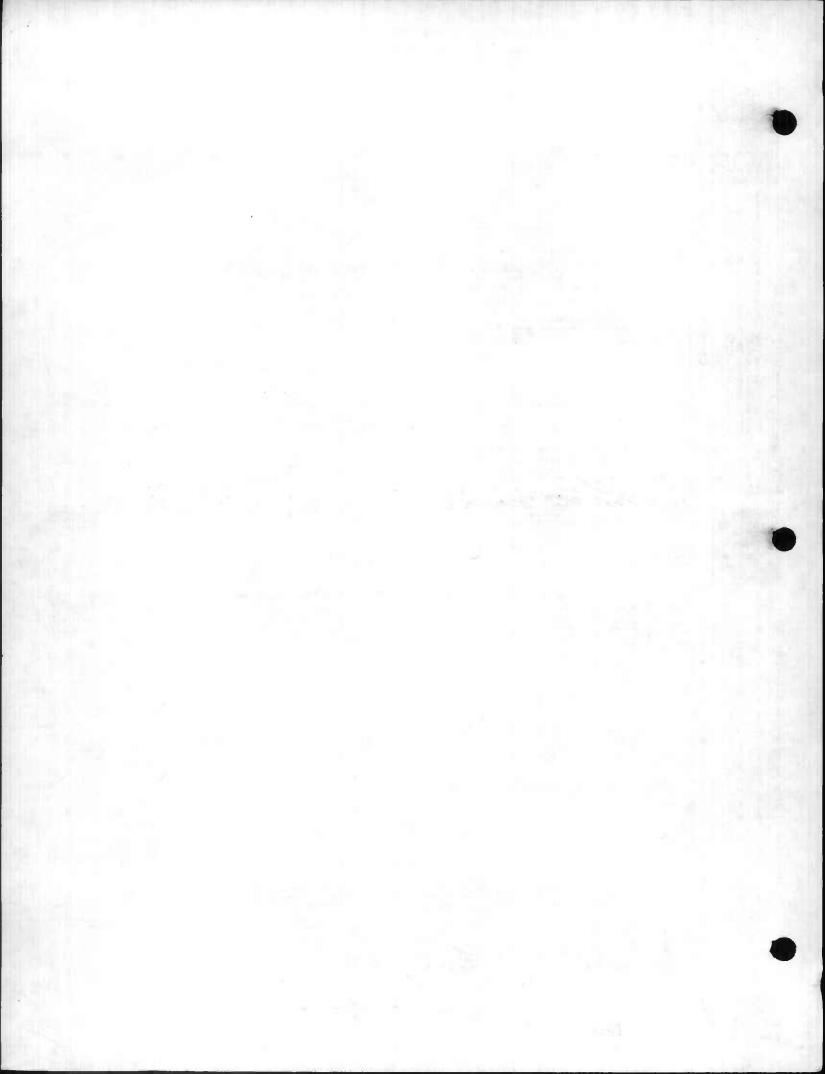
30. Name and address of paraon who completed cause of death (Item 23a) (Type, Print)

JACK M. Titus, M.D. 111 Penn 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year) MAR 2 0 2000 32. Registrar's Signeture

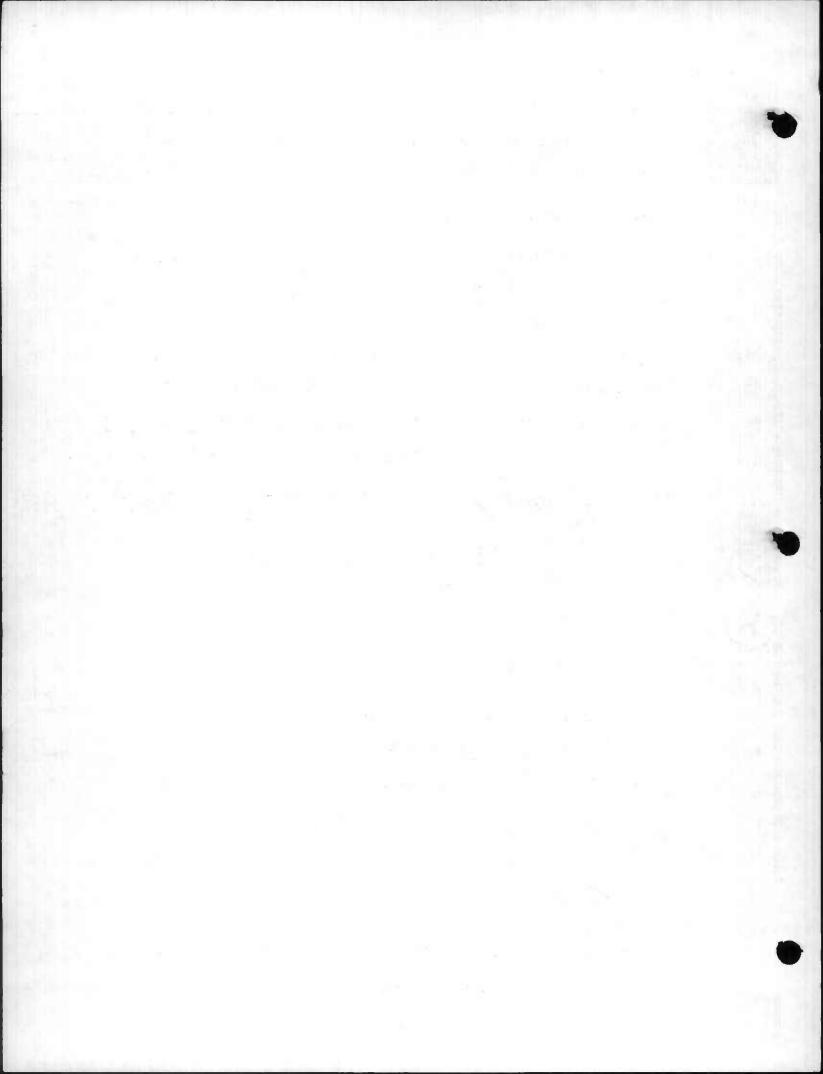
State Registrar

DHMH 16 Ray 6/95



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Amende	ite	em#23a perPHYG781 3,	18/2000 EW	Waryland /	Department of Certificate of			Reg. No.	08994		
Physic	ian	1. Decedent's Name (First, Midd					2. Date of Dea Month	Day Va	3. Time of Death		
/Medi		John Robe						18,2000	5:25 P.M		
Exami	ner	4a. Facility Name (If not institution			ndolle	4b. City, Town, or Dunda	Location of Daath	4c. County of D			
		Heritage Num 5. Social Security Number		ter/ Du . Age (In yrs. last I							
Funeral Director		213-05-2520	1 1 M 2 □ F	85	Yrs. Months Day			, Year)	Birthplaca (State or Foreign Country) Maryland		
pus *		Usual Residence of Decedent 10a. State 10b. County		10e City To	wn or Location				40d Incide Oils Limite		
f sho	or		alto.	Jop					10d. Inside City Limits 1 ☐ Yas 2 ☐ XNo		
filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23s or 28s-f show ont, tre Medical Experience must be notified at	Director	10e. Streat and Number			10f. Zip Code		1	10g. Citizan of What			
23a or		1038 Ensor	r Drive		210			U.S.A.	Country		
Jeath The 2:	Funerai	11. Marital Status	12. Was Deced	lent Ever in U.S.			Specify Yes or No-		American Indian,		
l', or items	by Fur	1 ☐ Never Married 2 ☐ Mar 3 🖫 Widowed 4 ☐ Divorced	ried 1 ☐ Yes 2	cas? 2 DXNo	13. Was Decedent of If Yes, specify Cu		rto Ricen, etc.)	Black, V Specify: [Vhite, etc.		
2 ho		15. Deceder	it's Education	16	a. Decedent's Usual Occ	upation		16b. Kind of Busine	ess/Industry		
Bo "n	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-	4or 5+)	(Give kind of work don life. DO NOT use reti	e during most of wo red)	orking				
Hygian ther the	Con	12			Butcher			Meat F	acking Co		
- 0 5	Be	17. Father's Name (First, Middle,					me (First, Middle,				
	P	John C. Grin						eubschman			
		19a. Informant's Name/Relations			b. Mailing Address (Stre						
f Health fram 27 I		Rosemarie Se	eliert		1038 Enso	or Dr.,	Dete Dete				
o = in		1 Burial 2 Cremation		cemei	imore-Wasl	ington		20c. Location - City Laure			
Department: any injury once.		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Dait			2 22 00	Daure			
Departm poorts any inju		T7 / A A	Licenses	1	22. Name and Add	Achton	Matthor	a Funore	.1 11 -		
Physician /Medical Examiner		23a. Pert1. Enter the disease, or shock, or heart failure. List Immediate Ceuse (Final disease or condition resulting in deeth)	complications that only one ceuse on	Acut	2 Reno	1 0	ac or respiratory and		Approximata Interval Between Onset and Death		
	ē		Di	EHYDRATION	a consequence of):						
and and selections	Examine	b. Due to (or as a consequence of):									
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1	dical	thet initiated events rasulting in death) Last	С	Due to (or as a	consequence of):						
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Strug for up	ian/		0								
y the a	Physician/M	Part It. Other significant condition	ons contributing to dea	th but not rasulting	In the underlying ceusa of	given in Part I.	23b. Did to	obacco use contrib	oute to the cause of death?		
ed by the detached	P.	Bilater	al Pr	eumo	rias		1 🗆 1	fes 2□No 3□	Probably 4 Unknown		
5.8	d by						24a. Was a	an autonou I 2	b. Were autopsy findings		
been signed b	Completed	_ End S	tage	1)em	enda		perfor	med?	available prior to completion of cause		
has ye 2	mp	Densey	Q -	N					of death?		
certificate h		ranging	sons	Dise	ase		1 U Y		1 ☐ Yes 2 ☐ No		
	9 Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 ☐ No	Hospital:		To	Whor	eath (Check only or				
	J: To	1 ☐ Yes 2 ☐ No 27. Menner of Death	1 ∐ Ing 28a. Dete of (Month)	patient 2 ER/0	Outpatient 3 DOA Time of 28c. Injury	4 W Nursing		ence 6 Other (5	specify)		
r death. octor: Aftar by the funer	tior	1 Natural 5 Pendir 2 Accident investi		, Day Year)		ork? □Yes 2□No		,,,,,			
after death Director: A d in by the f	Certification:	3 Suicide 6 Could determ	not be	of Injury - At homa, g, etc. (Specify)	farm, street, factory, office	8	28f. Location (S City or Tow	itreet and Number o n, State)	r Rural Route Number,		
ST ST ST	aic	(Check only 2 Medical	g Phyaictan: To the b Examiner: On the bas and manna	is of exemination a	ge, deeth occurred at the nd/or investigation, in my	time, date end plec opinion, death occ	e, and due to the ourred at the time, o	cause(s) end menne date and place, and	r es stated.		
a 24 hot	D D	one)							due to tha causa(s)		
within 24 hot To the Fune completely fil	Medicai	29b. Signatura and fittle of certifia	0		29c. Licar	nsa number	2	29d. Data signed (M			
within 24 hours after of To the Funeral Direct completely filled in by	Medic	one)	· Den		29c. Licar	nsa number	-1 1	-/	onth, Day, Year)		
within 24 hor To the Fune completely fil	Medic	29b. Signatura and little of certifia	vho completed cause	of death (Item 23a	D D	nsa number 5267	-1 }	-/	onth, Day, Year)		
To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the	Medic	29b. Signatura and little of certifia	i Jew	of death (Item 23a	D D	nsa number 5267	Pd G:	-/			



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Date of Death 3. Tima of Death **Physician** 2000 MARCH 14 8:35am Mattie Hardy /Medical 4a Facility Nama (If not institution, giva streat and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number 6. Sax 8. Date of Birth (Month, Day, Year) 7. Aga (In yrs. last birthday) Birthplace (Steta or Foreign Country) **Funeral** Months Days Hours 1 M 2 F 215-40-9689 Director 96 04/12/1903 North Carolina Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic evant, the Medical Exacting must be notified at 1 Yes 2 No Director Maryland **Baltimore** 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 1800 W. Hollins St. Apt. 325-W 21223 U.S.A. Funeral 12. Was Decedent Evar in U,S Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yes or No If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 1 ☐ Never Marriad 2 ☐ Married 1 ☐ Yas 2 XNo if Yas, Giva Yaar or Datas: 1 Yes 2 No Specify: Specify: Black 3 ∑Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decadant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elamantary/Sacondary (0-12) Collega (1-4or 5+) Factory Worker Warehouse 17. Father's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Degraffenreid Sr. Mollie Forshe 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if from 27 is any injury or other tra-pnce. 5913 Radecke Ave. Apt. K Baltimore, Maryland 21206 aca of Disposition (Nama of Data 20c. Location - City or Town, Stata Merman Farrell / Niece 20b. Placa of Disposition (Nama of cematery, cremetory or other plece) 20a. Mathod of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Zion Cemetery 3/18/00 Landsdowne, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funeral Service Licer 22. Nama and Addrass of Facility Derrick C. Jones Funeral Home 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heer feilure. List only one cause on each line. Approximata Interval Between Onset and Death Physician /Medical Immedieta Causa (Final PANCREATIC disaesa or condition resulting in death) Examiner Sequantially list conditions, if any, laading to immadieta causa. Entar Undarlying Ceuse (Diseasa or Injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Physiclan/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Heart Congestive þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 10 25. Was casa rafarred to medical axaminar? Be 26. Placa of Death (Check only one) Hospitel: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No 2 ER/Outpatient 3 DOA 27. Mennar of Death 28b. Tima of 28d. Describe how injury occurred

Examiner slcian and burial-trans P.O. Box 68760, Records, Sign Division of Vitai or Attanding Physician: funeral director, Medical Certification: To death. after deatl hours 24 hours Hospital

1 and 2 should be filed within it Health and Mental Hygiene.

1 Natural

5 Panding invastigetion 6 Could not be determined 28a. Dete of Injury (Month, Day Year)

28e. Place of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

MO

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 Accidant

3 ☐ Suicida

4 Homicide

12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, data and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifiar

D 00

203

29d, Date signed (Month, Day, Year)

BALTIMORE MD 21204

30. Name and address of parson who completed causa of death (Item 23a) (Type, Print) Char

31. Data filed (Month, Day, Year)

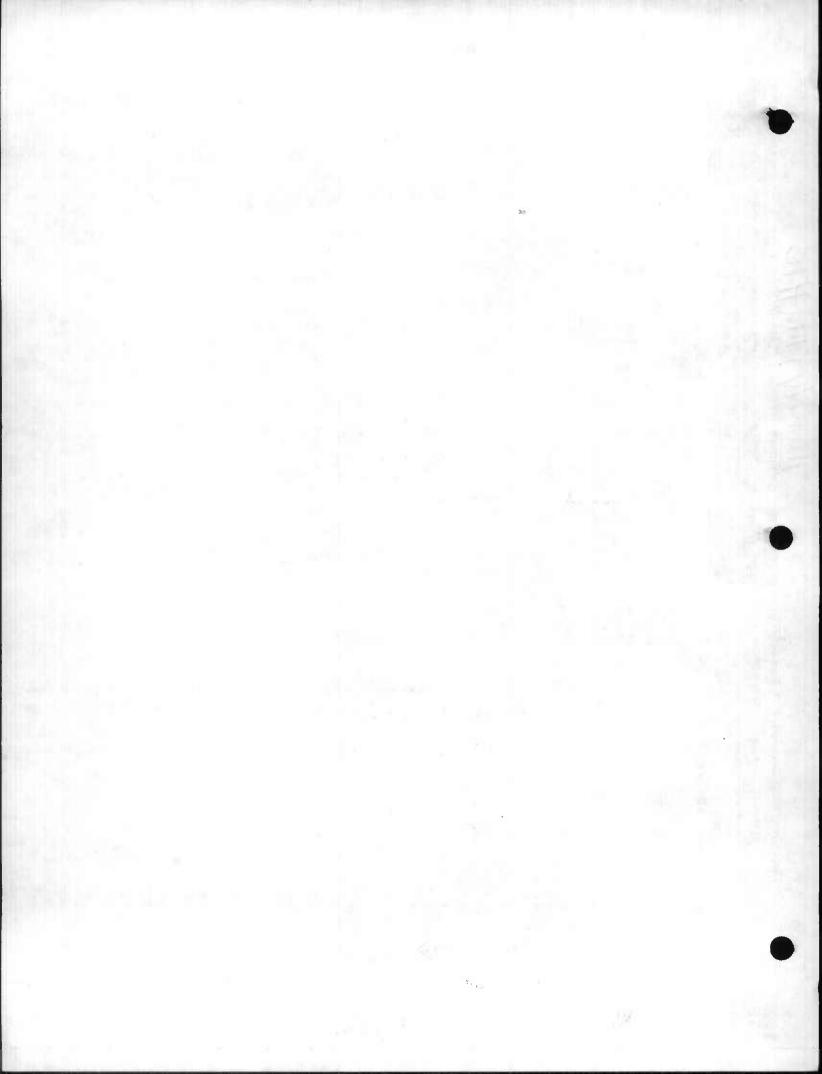
32. Registrar's Signatura

DHMH 16 Rev 6/95

completely

State Registrar

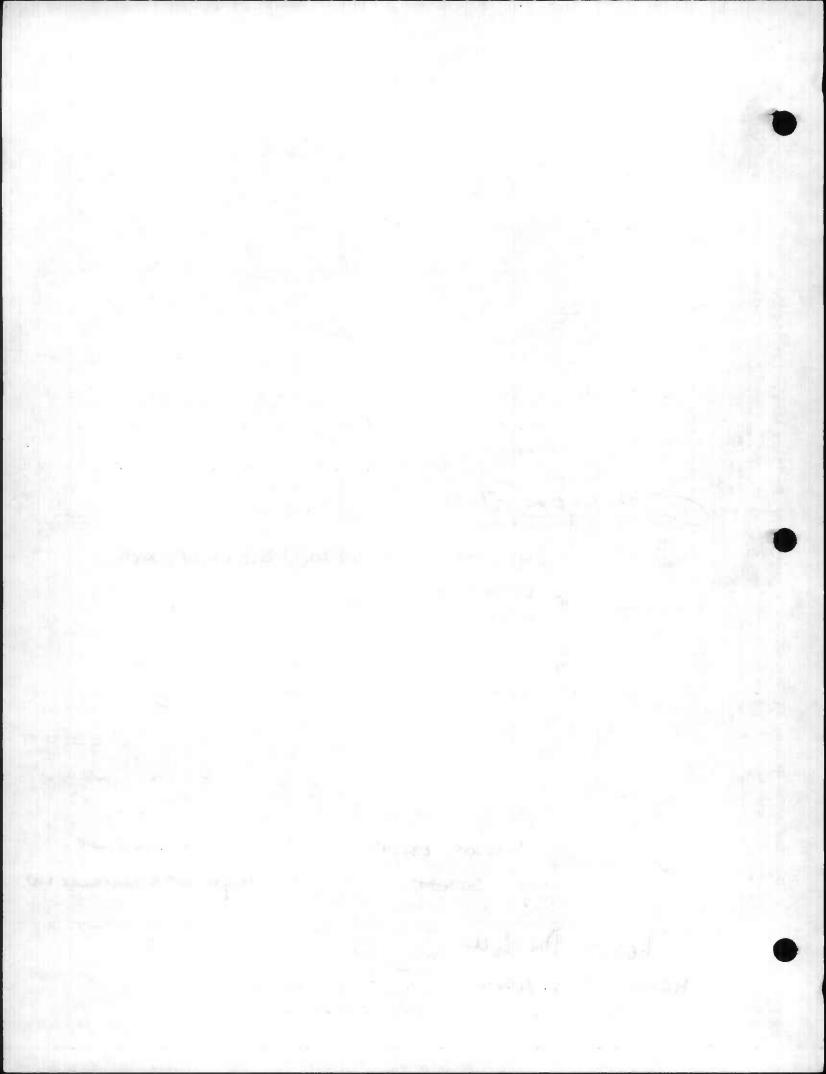
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State of Maryland / Department of Health and Mental Hygiene 00 08996

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400	Physician /Medical	Kevin	Johns	son		Month MARCH	15, 20	Year 000	2328 PM				
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		1520 EAST 3	oth Street	·			BA	LTIMO	RE				
-	Funeral	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1	ear If Unde	er 24 Hrs.	8. Dele of Birth (Month, Day	Voor	9. Birthp	place (State or Foreign	
	Director	217-94-6052	10XM 2□ F	20	Yrs.	MONITS	eys Hours	PVIII).	03 12	80		. D.	
	9 .	Usual Residence of Decedent											
	app of the	10s. State 10b. Count	1		y, Town or Lo						1	10d. Inside City Limits	
	A THE O	MD NA		Ba	ltimo	re						1 N Yes 2 No	
	ter death with the Maryland thems 23a or 23a-f show their must be notified at funeral Director	10e. Street and Number				10f. Zip Co	de		1	log. Citizen of V	What Coun	ntry?	
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	there death of the same same same same same same same sam	11. Marital Status	12. Wes Dec	edent Evar in U, proes?	S. 13. \	Was Decedent If Yas, specify	of Hispanic Cuban, Mexic	origin? (Span, Puerto	ecity Yes or No- Rican, etc.)		e - Americ ck, Whita,	can Indian, etc.	
20	transfer or by F.	1 Never Married 2 Me	. If Yes, Gi	Ve		1 Yes 2	No Specif	y:		Specify	6		
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9		11th grade 17. Father's Name (First, Middle	last)		De.	livery		har's Nam:	a (First, Middle,			tz Furs	
an	D SUES												
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	Health Health Oher tr	Dana Johnson 20a. Method of Disposition	n-Sister	20h P		4 LOCI		en Bl		20c. Location -		more Md	
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		4300 Wabash Ave. Baltimore Md 21215											
		shock, or heart failure. Lie	t only one cause on a	caused tha death aach lina.	n. Do not ent	er the mode of	dying, such o	es cardiac	or respiratory arr	est,	i	Approximate Interval Between	
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	fleate be associted to physician and is the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying											
	erificate be associted ling physician and se as the burial-transit Medical Examir												
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	been signal							44.5	perfor		av	allable prior to empletion of cause	
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5	Physician: The is rible certificate ha rial director, page 1: To Be Com	25. Was case referred to medica examiner?	Hospital:				Other		h (Check only or				
0	this of the sidir	XX Yes 2 No 27. Manner of Death	10		ER/Outpatien		411	-				M AT SCENE	
2	Ion Line	1 Natural 5 Pendi	130	th, Day Year)	28b. Time of Injury	On a	Injury el Work? 1 Yes 2		28d. Describe h				
8	ton the	2 Accident Invest 3 Suicide 6 Could	not be	2-00	2320					su ws			
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	n 24 hound n 24 hound he Funer pletsly fill	29a. Certifier 1 Certifyle (Check only XX Medical	ng Physician: To the Examiner: On the b	asis of examinet	vledge, deelh ion end/or inv	occurred el ti vastigation, in	na tima, data a my opinion, de	and plece, seth occurr	and due to the c red at tha time, d	ause(s) and ma lata and place,	and due to	itated. o the cause(s)	
	To the Heaptial or Attending Physician 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification: 7	29b. Signature and title of certific		ner steted.		200 13	censa numbe	,		9d. Date signe	d (Month	Dev Yearl	
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	4	30. Name and address of person	1 11								201		
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1 X Yes 2 □ No 26. Plece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury et Work? 28d. Describe how tniury occurred 5 Pending Investigation Naturat 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 🖔 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and piece, end due to the cause(s) and manner stated.

Box 68760 P.O.

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Physician

/Medical

Examiner

Funeral

Director

r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filled within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any injury or other traumatic event, the Medica once.

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Baltimore, Maryland 21215-0020

State Registrar

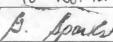
Psoltimore

29b. Signeture end title of cartifier

U.A.

30. Name and eddress of person who completed cause of deeth (Item 23e) (Type, Print)

Hospital 32. Registrar's Signature



Worth Greene St.

29c. License number

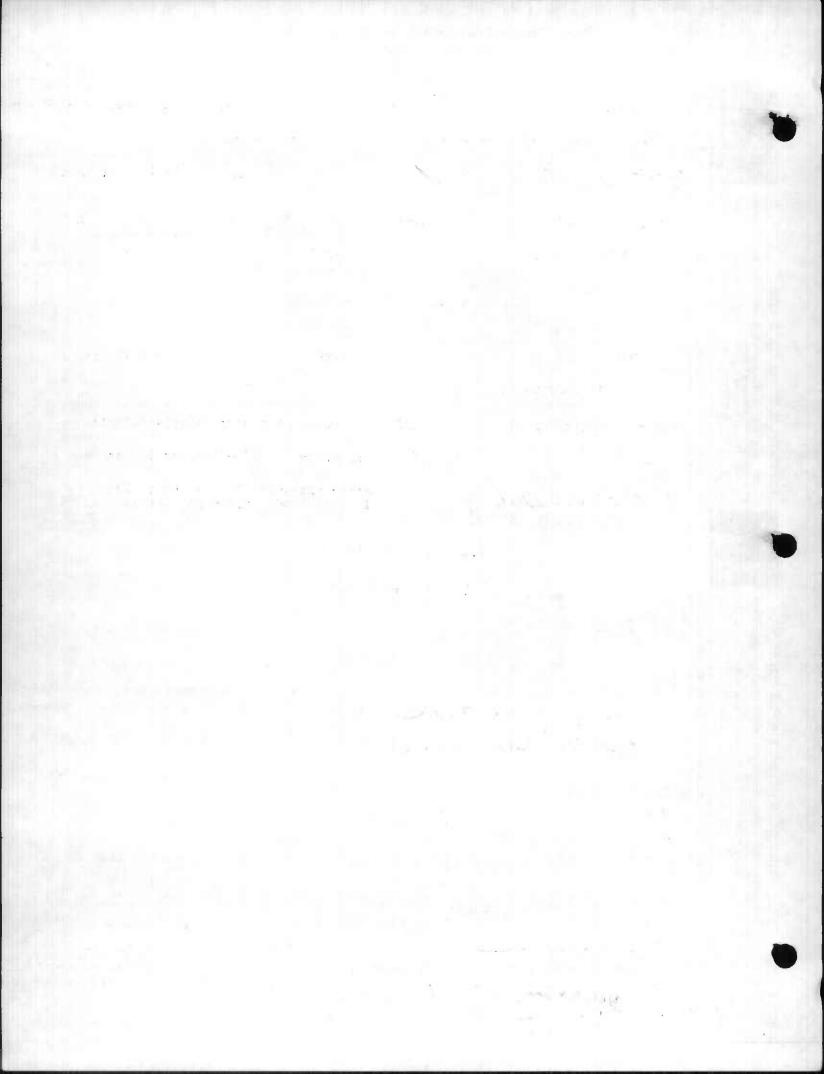
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29d. Date signed (Month, Dey, Year)

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21201

Baltimore, MD



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month . Jeter March 2000 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospital Bastimore Secours If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Days 10 M 20 F Months Hours AROI Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Evar in U.S. Armed Forces? 1 ☐ Yas 2 ☑ No 14. Race - American Indian, 11 Marifal Status Black, Whita, atc. 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates: 3 ₩idowed 4 Divorced LAK 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MARY ANDREW 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of pernetery, crematory or other) 20a. Method of Disposition 20c. Location - City or Town, State matory or other 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 8 ☑ Other (Specify) 21. Signature of Juneral Service Ricenses na disease, or complications that caused the death. Do not all failure. List only one cause on each line. Approximata Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy completion of cause of death? 1 Yes 2 No 1 Yes 2 No 26. Place of Death (Check only one) 1 Inpafient 2 ☑ ER/Outpatienf 3 □ DOA

Physician Examiner P.O. Box 68760. Records, Division of Vital To the Hospital or Attending Physician:

Physician

/Medical

Examiner

Funeral

Director

must be notified at

"naturel", or Herna

Peges 1 and 2 should be filed within nent of Health and Mental Hygiene. Int: If Item 27 is marked other than Irry or other traumatic event, the M

Department of Important: If eny Injury or

/Medical

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within 24 hours a To the Funeral C

director.

2

the Medical Examiner

Funeral Director

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Be Completed

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Examiner

with the Maryland

filed within 72 hours after

21215-0020

Baltimore, Maryland

Physician/Medicai Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. p Be Completed 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 2 Natural 1 Yes 2 No 2 Accident 6 Could not be 3 Suicida 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) State Registrar

SALVATORE

BON SECOURS HUSPITAL - EMERGENCY DEPT MD 32 Aegistrar's Signature

14

2000 W. BACTIMORE ST BALTIMORO

13/00

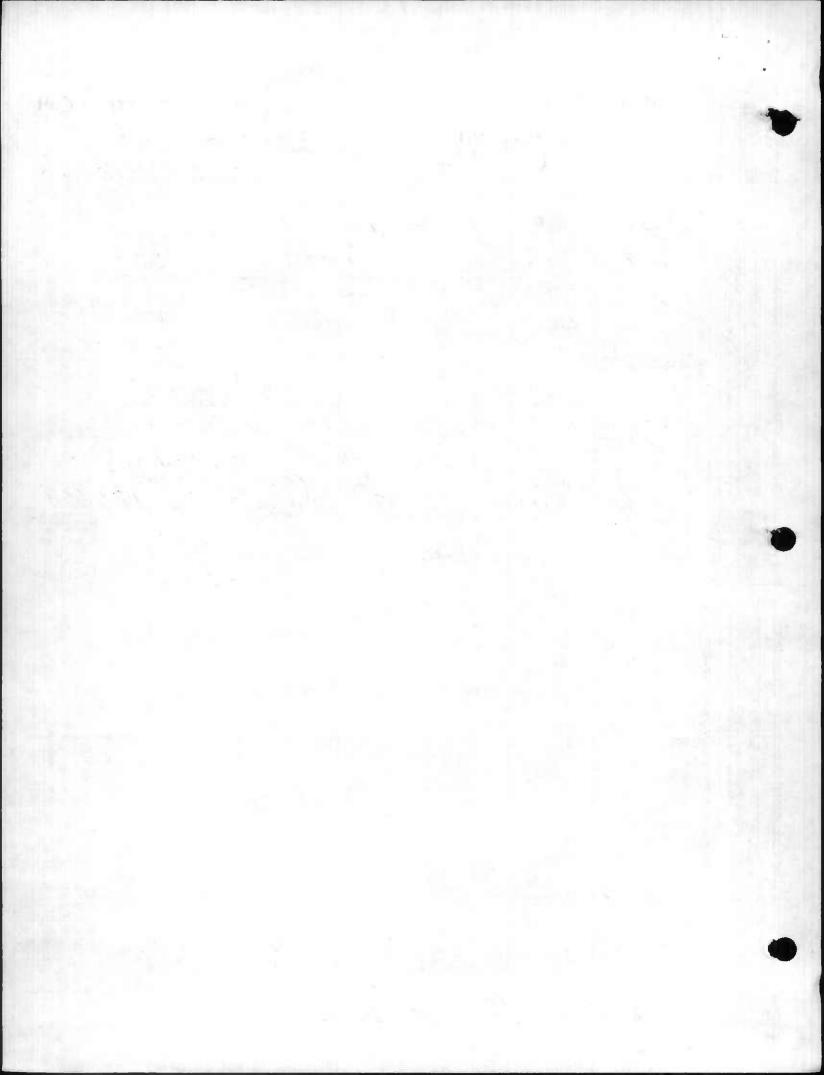
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chliatore

30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

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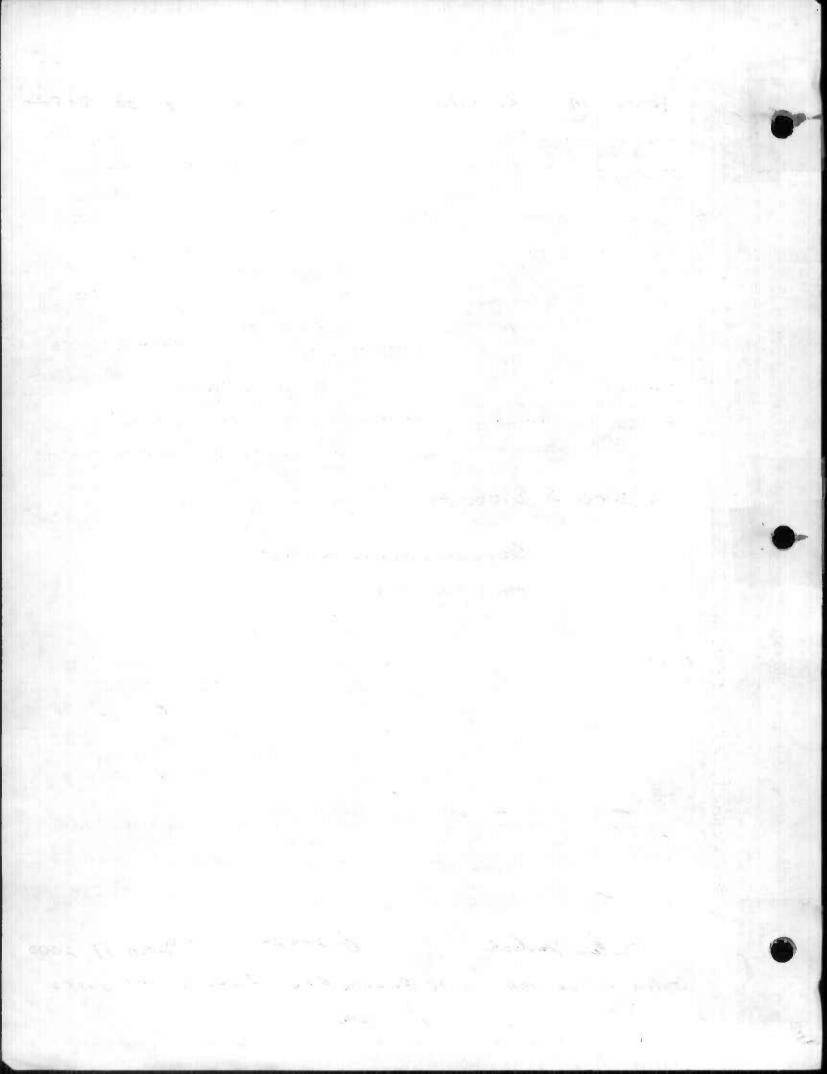
DHMH 16 Rev 6/95

State

Registrar

32. Bégistrar's Signature

Deperma



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** nlors 12n larch 1,2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lutherville 1610 Green Spring Drive Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) 2-18-1915 9. Birthpiace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In yrs. lest birthdey) **Funeral** Days 1□ M 2□ F Months Hours Min Yrs. Director 85 219-05-0469 Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No Directo Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 1610 Green Spring Drive 21093 U. S. A. death Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Maryland 21215-0020 If Yes, Give Year or Dates: 1 Yes 2 No Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 7 and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Unicav Co. Keypunch Supervisor 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofter any liqury or other traumatic event poss. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Margaret Greenfield Henry Doerfoer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 903 Mrs Carolyn F. McCorison (Dtr) Railroad Lane, Orrtanna, Pa. 17353 altimore, 20b. Place of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition Dete 20c. Location - City or Town, State 1 ♥ Burial 2 Cremation 3 Removal from State Gardens Of Faith Cemetery 3-22-00 Overlea, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. roots, of allace 1050 York Road, Towson, Md. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final ardio Vasculas disease or condition resulting in death) eriosciero/ic Examiner Due to (or as a consequenca of): Examiner law requires that the death certificate be executed physician and s the burial-trens Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical Due to (or as a consequence of) for use as t P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. the 23b. Did tobacco use contributa to the cause of death? signed by the 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Kinknown Records, P been si 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? certificate has t The 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital or Attanding Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: 4 Nursing Home 5 Residence 6 □Other (Specify) To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Dey Year) Certification: 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Netural 5 Pending deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: / 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homloide To the Hospital or within 24 hours eff To the Funeral Di completely filled in 1 Carilying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier edicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20011 address of person who commetted cause of death (Item 23e) (Type, Print) 30 Name at 122 DONNELL MI 31. Date filed (Month Aak

32. Registrar's Signature

Deneva

2000

State Registrar

